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Note: *Now forthcoming issue of the* ***Journal of Indian Health Psychology*** *will be published in Janaury and June of each calender year.*

EDITORIAL

This issue of the *Journal of Indian Health Psychology* has six research articles that focus on the various aspects of health and illness. The articles in the current issue are based on either quantitative or qualitative methods with a critically oriented approach. The first article by Megha Singh, Arshi Islam, Farah Khan and Pallavi Bhatnagar explored the problem of sexual violence using a thematic analysis of the perceptions of youth. Pragya Verma and Archana Shukla, in the next article, discussed the efficacy of CBT in managing social anxiety in a 25-year-old pregnant woman. The next article in this issue by Gulgoona Jamal examined the heterogeneity of the "friendship network" of Indian young adults. The author found that males and females showed a fusion of heterogeneity and homogeneity in their "friendship network", with males having a tilt towards heterogeneity and females towards homogeneity. The next article by Swaha Bhattacharya and Piyali Roy talks about the association of social relationships with health and well-being. Ganesan V and Ramakrishnan K S assessed the effect of behaviour technology in the enhancement of helping behaviour among students.

The journal provides a platform for empirical research, comprehensive critical reviews and intervention-oriented articles in the field of health psychology and for application in a wide range of contexts. Editors express gratitude to all the authors for their research contributions. Editors are also grateful to the referees and members of the editorial board for their valuable inputs and suggestions. The journal aims to sensitise the readers about health-related issues and promotion strategies that would help pave the path towards healthy and flourishing individuals and communities.

Editors

CONTENTS

THE PROBLEM OF SEXUAL VIOLENCE: THEMATIC ANALYSIS OF THE PERCEPTIONS OF YOUTH

Megha Singh[1], Arshi Islam[2], Farah Khan[3] and Pallavi Bhatnagar[4]

Abstract

Problem solving is a process to reach the solution of the problem in a systematic and structured way. With increasing gender violence against women, the need of the hour is a preventive intervention towards exploring and changing the attitude towards this problem. The present research is a step in this direction. The purpose of the study is to explore the perception of sexual violence as a problem using Kahney's approach of problem solving. The sample comprised of 125 young students of Lucknow city. The research design was Ex-Post Facto research. The thematic analysis of the responses brings forth manifestation, causes of sexual violence, sociocultural fabric and consequences of sexual violence as the dominant themes of perception of the problem of sexual violence (initial state). Three themes emerged in the solution to the problem of sexual violence (Goal state) viz. preventive intervention, empowerment of the girls and provision of strict legal, police and community protection of girls. Barriers to reaching the goal (the controls) consider social taboos, patriarchal society and lack of awareness and education as the dominant themes. Lastly, improving legal protection and increasing the level of awareness were the two themes that emerged for strategies in reaching the goal (The operators).

Keywords: *Problem solving, kahney's approach, sexual violence, initial state, goal state, controls, operators, thematic analysis*

"Sexual violence violates a person's right to bodily integrity since in most cases it is mostly exercised over women without their valid consent and it also affects the victim's physical and psychological health".

—McAnulty and Burnette (2006)

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Gender specific crimes are characterized as crimes against women. A total of 4,05,861 cases of crime against women were registered during 2019 showing an increase of 7.3% over 2018. The crime rate registered per lakh women population is 62.4 in comparison with 58.8 in 2018 (NCRB report, 2020).

Crime against women has a wide range of violations including physical, sexual and emotional assault, predisposing them to lifetime of trauma and suffering. Predominantly it includes rape, sexual abuse, assault to outrage her modesty, kidnapping and trafficking.

The statistics sends shiver down the spine with one rape reported every 16 minutes in India in 2019 (NCRB report, 2019). States of Rajasthan has highest number of rapes in India (Khan, 2020). Besides, states of Madhya Pradesh, Uttar Pradesh, Haryana and Chhattisgarh also have the highest incidence of sexual violence against women (Das, 2020). Ironically, various studies present evidence that 99% cases of sexual violence go unreported due to the fear of stigma and humiliation (Shanmugam, 2013). The gravity of the problem can be gazed by the fact that India has the largest number of child sexual abuse cases in the world (Taman, 2021).

What perturbed the researchers was that with the backdrop of deep rooted patriarchy in Indian society the power equations still reflect a hierarchical system justifying the discriminating acts and violence against the women. The researchers reaffirm the concern of Margot Wallstrom (the former secretary general of UN) that women's bodies are being construed as invisible battlefields and rape being accepted as cultural, the question comes to the mind is sexual violence not inevitable? (UN News Center, 2010). With violence against women remaining as one of the most serious challenges of our times the present study employs a qualitative approach of exploring the perception of the youth regarding problem of sexual violence.

A cross cultural study by Maplecroft on sex trafficking and crime against minors showing India as ranking 7th worst (Warhurst, Strachan, Yousuf and Smith, 2011). Number of minors under 18 years are taking to crime at an alarming rate over the past decade. Each day 3 minors are being arrested for rape, assault and attempted violence on each day in 2019 (Times of India, 2019). This is a cause of concern for a country where 39% of it's population is below 18 years.

Thus, both the perpetrator and the victim over represent the youth. What goes in the mind of these growing kids?How do they process sexual abuse as a problem and do gender differences figure out prominently in the mental space of processing this problem were some of the questions which intrigued the researchers to undertake the present study.

Evidence suggests that lab made problems, mathematical problems and structured problems are easily solved as their problem space is clearly defined,

fitting in the description of a well defined problem meeting the criterion of well defined initial state, goal state, operators and controls (Matlin 2009, Eysenck and Keane, 2005) However, social problems not having a very clearly defined structure are also often left unsolved because of an incomplete perception and being ill defined (Kahney, 1986).

What was felt strongly by the researchers that if the perception of the problem of the sexual violence was incomplete, inadvertently the goal state or the solution would also not be construed properly and subsequently the obstacles in reaching the goal, as well as, the strategies for resolving the problem would also be an issue worth exploring. The successful solution of a problem is contingent upon a complete perception of initial state, goal state, operators and controls of the problem.

Method

The purpose of the studywas to explore the perception of youth for the problem of sexual violence usingKahney's approach to problem solving. The research design was Ex-Post Facto research with an exploratory orientation. The sample comprised 125 students the age range of 15 years to 20 years belonging to middle socio-economic status in Lucknow city. The subjects were equally divided into gender and were willing to participate in the study. The one to one interview was based on five major questions. The responses were verbatim recorded by the second and third researchers.

Q1. Is sexual violence a problem? Yes/No

Subsequent to the answer in affirmative, they were asked-

Q2. How do you see it as a problem? (Initial state)

Q3. What according to you is the solution of the problem? (Goal State)

Q4. What according to you are the barriers or obstacles in reaching the solution? (Controls)

Q5. What according to you are the strategies to reach the solution? (Operators)

Results

The currency of life is lived and felt experiences and the qualitative analysis of the same brings one closer to their world view and understanding of the mental representation for a problem. As most of the data was qualitative, hence verbatim transcription of the verbal data was converted in the written form. It was ensured that transcript retained its original form, hence the results are bilingual. In order to get familiar with the data the transcripts were read a number of times. Thereafter, the codes were generated, coding was done manually using line by line approach where each sentence was read to generate codes and subsequent themes. Then themes were refined and given a name to reflect the essence of the data. The most dominant themes are being discussed here for each question.

I Sexual violence as a problem

100% respondents gave responses in affirmative.

II Perception of the problem of sexual violence (Initial state)

Sexual violence is a profound violation of human rights. According to CEDAW (general recommendation 19) gender based violence such as rape is an extreme form of discrimination seriously inhibiting women's ability, rights and freedom on a basis of equality with men (CEDAW 19, A/47/38)

Four most dominant themes were reported by the participants with reference to their perception of sexual violence as a problem-

1. **Many faces (kinds) of sexual violence (Manifestation)** viz. staring, commenting and wrong gestures including voyeurism.
2. **Causes of sexual violence** viz. faulty parenting, forced marriages and lack of education.
3. **Sociocultural fabric** viz. patriarchy, cultural factors.
4. **Consequences of sexual violence** viz. torture, killing, rape and blackmailing, emotional and physical trauma.

Largely girls enumerated the kind of sexual violence as "It is awful when you are stared at or someone passes a vulgar comment and makes wrong gestures publically". In terms of the theme of the causes lack of education emerged prominently "I think girls should be educated so that they are aware and are in a safe environment. Those who are illiterate are subjected more to violence than the educated ones."

The theme of Sociocultural Fabric highlights the role of patriarchy. It is pervading since generations that women is being looked down upon and is considered as weak. Her identity is through her husband only and therefore she always suffers oppression. (*Ye to sadiyon se chala aa raha hai, aurat ko hamesha kamtar aur kamzor dekha jata hai. Aurat ki pehchan hamesha uske aadmi se hoti hai isiliye wo julm sahti hai*)

Besides, theme of **Consequences of Sexual Violence** was highlighted in terms of torture, killing, rape and blackmailing "Sexual violence actually is rape and innocent girls are subjected to blackmailing. Some are killed after the crime and some commit suicide".

Both boys and girls conceived sexual violence in terms of a trauma "It is not just the body that has been scarred but mentally and emotionally the girl lives in a trauma state all her life, besides feeling unsafe to venture out".

The youth's perception of the problem of sexual violence (initial state) fits in the definition of sexual abuse given by IPC (Section 354) "It is any act against women that will outrage her modesty like sexual assault, harassment, voyeurism, stalking, human trafficking and rape".

III The Solution to the Problem of Sexual Violence (Goal state)

The perceived solution of the problem brings out three major themes-

1. **Preventive intervention** viz. increasing awareness about the problem, quality education, creating positive attitude, changing mindset of parents for a proactive positive attitude for the girl child.
2. **Empowerment of the girls** viz. making them more independent and have self defence classes.
3. **Provision of strict legal, police and community protection of girls** which not only has the response category of making strict laws but also reporting to police and women helpline. The role of government is also highlighted.

With reference to Preventive intervention responses pertaining to Quality Education "If people in our society are educated and aware this issue could be resolved, there are so many illiterate people all around us."Another participant responded on the same note"If there was education then daughters in our country would be safe" (*padhai likhai hoti agar to humare desh me in betiy ansurakshit rahti*), "Parents are more worried about their daughters and their marriages rather than giving them education" (*Ma baap apne betiyon aur unki shadi ki fikr jyada karte hai bajye unko padhane likhane ke*).

With reference to stringent and strict laws responses were somewhat like "I don't think so people are scared of the government which is why they do these heinous crimes freely without any fear of punishment". Besides, the role of government was also emphasized and it was pointed out "Everything is in the hands of government. We cannot do anything unless the government desires so".

Taking the paradigm of Transactional analysis it may be said that social problems have their solutions within the community only. The three P's for empowerment are Potency, Permission and Protection. The changing power equations do give the permission to the girl to assert, affirm and evolve out of the barriers of the traditional mindsets and the women of today are definitely making a dent in the male dominated industries and roles also. However, the protection and potency are weakened when the struggling female falls prey to such heinous crimes as sexual abuse. Our policy makers, as well as, the society need to think about giving protection along with permission to thrive.

IV Barriers in reaching the Goal (The Controls)

Barriers to problem solving are cognitive blocks that impede the ability to correctly solve problems. These can be perceptual, emotional, intellectual, expressive, environmental, and cultural. The Problem solving approach is moving from aninitial state to a goal state, through barriers. To solve the problem in the most efficient manner the respondents were asked "what according to you are the barriers in reaching the goal"?

With reference to the perceived obstacles in reaching the goal/ solution once again the society plays a major role as most of the perceived obstacles by both males and females are imbibed in the sociocultural fabric of the society.

Thus, three major themes pertaining to Barriers to the goal are as follows-

1. **Social Taboos and little or no action (Passive attitude)** viz. social taboos of stigma, fear of discrimination by society bringing bad name to family and strong execution of laws are missing.
2. **Patriarchal Society** viz. discrimination in rearing, neglect of girl child, age old mindsets of male supremacy.
3. **Lack of awareness and education**

There are lot many social taboos in our society for girls and fear of shame and guilt leads to underreporting of such cases. Besides, the sociocultural fabric of patriarchy is at the base ofage old mindsets of community and particularly the traditional and indifferent attitude ofauthoritiestowards females responsible for execution and enforcement of the laws. Hence, strong proactive action taking action against the perpetrator is very marginal in a number of states.This is evident through the narrative of the theme "There is lack of trust and even the parents do not believe that any such crime has been committed. They hold the girl responsible for all sexual violence including rape which is pathetic and makes such girls live with feelings of guilt, shame, sinfulness predisposing them to depression". One of the participants reported "The attitude of the government towards gender violence is careless and immature, with very little support for the victim".

In response to the theme of Patriarchal Society responses focused on such narratives "The social structures and practices will always be a barrier for women, the patriarchal attitudes and economic dependence of women still lives on."Another participant responded "The old rituals and thought processes of people will not let them move ahead. Whatever their forefathers have taught them they will believe in that only. Even if the girl is literate they are not allowed to work because of their old thoughts" (*Logo ke purine khayal aur gharmein purine reeti rivaz ka bhi unko aage nahi badhne denge. Jo unke baap dada kahte aayehai log wahi mantehai. Jinke ghar mein ladki ya padh likh bhi jati hain phir bhi unhe kuch nah I karne diya jatah ai kyonki soch bahut dhakiyanoosi hoti hai*).

Significantly the theme of lack of awareness in terms of better education, sex education, holding awareness program was brought forth by the narratives viz. "There needs to be various programs like gender sensitization. Gender sensitization is a basic requirement to understand the basic needs of gender and such awareness can help in reducing gender violence but it is not there."

V Strategies in Reaching the goal (The operators)

There are a number of different ways that people go about solving a problem. It is very important to get a plan of action to find a solution for a problem. The

content analysis of the perceived strategies to reach the solution or the goal state brings some very intriguing results.Predominantly the strategies like the perceived goal state bring to fore the need for intervention at the community level. Two major themes emerged-

1. **Improving legal protection** viz. speeding the judicial process, setting and implementing more strict laws.
2. **Increasing level of awareness** viz. inclusion of topic in school curriculum, holding various awareness programs.

With reference to Improving Legal Protection the perception of youth brings forth narratives like "I believe that strict laws can curb the crime", "We should go for fast track because justice delayed is justice denied".

At this point it is worth reporting that education and it's needs not only figure out in the solution to the problem and strategies of sexual violence but also emerges prominently as a cause of sexual violence (in perception of the initial state) as well as, barriers in reaching the goal. Infact, the goal state to the problem of sexual violence as envisioned by young students seems to have overlapping themes with the strategies in reaching the goal (the operators).

Hence, what emerges clearly is the need for a proactive approach to address the issue at the community level, bringing a change in their attitude not only towards the girls but also the problem of sexual violence which so often is at the base of translating the victim of sexual violence into the perpetrator. Although a ray of hope is in the offing with programs like Nari Shakti Mission, 1090 and women empowerment as well as speedy disposal of the cases by fast track.

The most touching part of this research was that most of the respondents felt very strongly for all three issues of Increasing Level of Awareness in affirmation and being a part of the community conveyed that "We can actually work towards a viable solution if not by improvising legal protection, then we can be a part of the awareness campaign at different levels". This is one of the major finding of the study where a paradigm shift appears in their mental space of perception of the problem from other oriented to self oriented.

Social problems have their answers in social transformation. Further, as per Gandhi's model of community development also strongly advocates that community participation is at the helm of community Development (Dalal, 2000).

This grave social problem of sexual violence thus can also find plausible solution when not only the strength of the nation, that is, the youth (the sample of the present study) accept the problem and the possibility of the solution and also come forward with the ownership that 'I can do something about the problem'.

This study on a small sample was a window to the youth's mental representation of the problem of sexual violence. More efforts are needed to have

a means-end analysis meaningfully providing the three P's of Potency, Permission and protection to the girls to thrive and a greater understanding of the social problem of sexual violence.

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MANAGING SOCIAL ANXIETY DISORDER IN PREGNANT WOMAN THROUGH COGNITIVE BEHAVIOURAL THERAPY: A CASE STUDY

Pragya Verma[1] and Archana Shukla[2]

Abstract

The present case study endeavors to cast a glance at the treatment of social anxiety disorderin a pregnant woman through cognitive behavior therapy. The case study describes the successful treatment of a 25-year-old pregnant woman who was experiencing severe anxiety triggered by certain social situations and traveling. The symptoms were significantly affecting her daily life. The study aimed to assess the efficacy of cognitive-behavioral therapy (CBT) for individuals with social anxiety disorder during pregnancy and involved 12 sessions of therapy. At the end of the therapy, the patient's symptoms were significantly reduced, and relapse prevention tactics were taught to manage herself in future. The study suggests that CBT can be an effective treatment for social anxiety disorder during pregnancy.

Keywords: Pregnancy, social anxiety disorder, cognitive behaviour therapy

According to a 2014 study published in the Indian Journal of Psychiatry, social anxiety disorder (SAD) affects around 3% of the population in India, making it a common mental health condition. SAD is depicted by persistent fear or anxiety in social situations where an individual might be negatively evaluated by others, leading to significant impairment in their social, occupational, and academic functioning (American Psychiatric Association, 2013). Cognitive-behavioral therapy (CBT) is an effective treatment option for SAD, involving a combination of cognitive restructuring, exposure therapy, and social skills training (Acarturk et al., 2009; Hofmann et al., 2012; McEvoy et al., 2016). CBT is advised as the

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primary treatment for SAD, and it has been considered as better than other psychological treatments (Hofmann et al., 2012).

SAD can also occur during pregnancy, and it can have negative effects on both the mother and the developing fetus (Guardino & Schetter, 2014; Orr et al., 2002). Pregnant women with SAD may have greater stress hormone levels and have more depression and anxiety symptoms during pregnancy than women without SAD. (Guardino & Schetter, 2014). Furthermore, SAD during pregnancy can lead to avoidance of prenatal care, resulting in poor maternal and fetal outcomes (Orr et al., 2002).

Treatment options for SAD during pregnancy include CBT and medication, but it is important to discuss treatment options with a healthcare provider as some medications used to treat SAD may not be safe during pregnancy (Bandelow et al., 2018). Seeking professional help is recommended for pregnant women with SAD to ensure appropriate treatment and monitoring of maternal and fetal health. Untreated SAD can lead to the development of comorbid mental health disorders such as depression and substance use disorders (Stein & Stein, 2008). Seeking professional help can improve the chances of successful treatment and improve maternal and fetal outcomes.

Objectives of the intervention

- The intervention aimed to motivate the patient for therapy, prepare her to face anxious situations, reduce her anxiety, increase her self-esteem, and modify her negative thoughts.

The therapeutic package consisted of the following intervention techniques

1. Psycho-education
2. Systematic desensitization
3. Exposure and response prevention technique
4. Cognitive restructuring

Case Report -

Sociodemographics- Mrs. SS was a 24-year-old married female educated up to graduation, taking treatment for pregnancy at the department of Obstetrics And Gynecology at Integral Institute of medical science and research. She referred to the psychiatry department of IIMSR for CBT. The Department provides free of charge treatment sessions to all patients requiring psychological support.

History -Mrs. SS was diagnosed with Social Anxiety Disorder and three months pregnant . She was living with her spouse in Lucknow, as her parents live in a village. She was the only daughter in law. When asked about her childhood, she said that she had been happy and did not report any traumatic events. The patient reported having a good relationship with both parents and denied any history of psychiatric or psychological disorders or substance abuse

within the family. However, the patient has been experiencing severe anxiety symptoms for the last 7 months.

Clinical features- She has been experiencing severe heart palpitations, flushing, and a fear of fainting and losing control while traveling in cars, autos, and buses. Due to these anxiety episodes, she has become worried about the impact they may have on her pregnancy. In addition, the patient described experiencing chest pain and muscle tension during anxiety-provoking situations, which further exacerbated her fear and led her to avoid these situations, causing significant impairment in her daily life. The patient also reported experiencing similar symptoms when meeting new people due to concerns about being judged for her pregnancy. She sought medical attention multiple times to rule out any pregnancy-related health issues.

She stated that she didn't experience any symptoms of depression, had no prior psychological or psychiatric treatment and/or medication, and had first experienced this problem in the course of the current year. Due to her condition, she was not able to enjoy the period of pregnancy, which she always wanted, and now she decided to stay at her house because traveling and meeting new people is stressful for her.

Clinical evaluation- The patient was asymptomatic before 7 months, meaning she did not experience any symptoms related to anxiety or stress. She was able to perform household work and take care of herself without any issues. However, while traveling to the hospital by bus one day, she suddenly experienced symptoms of anxiety such as nervousness, fear, sweating, and a rapid heartbeat. These symptoms continued to bother her, and her stress levels increased due to her pregnancy.

The patient showed signs of restlessness and agitation, and preferred to be alone, avoiding social gatherings such as parties and family functions. When asked about the cause of her behavior, she mentioned being afraid of being judged negatively by others due to her pregnancy and her fear of traveling. She frequently argued with her partner and exhibited her anger through shouting, crying, and clenching her fists. Due to her unstable behavior, her partner would try to avoid arguments with her. After confirming her pregnancy, the patient became more aware of her health-related behaviors, which increased her stress levels. She began to avoid activities that she had previously enjoyed, and her episodes of social anxiety and heightened stress made her feel restless and worried. As a way of coping, she resorted to watching TV and spending excessive time on her mobile phone, mostly watching pregnancy-related health videos. This distraction prevented her from engaging in healthy behaviors that could help alleviate her stress and anxiety.

The patient's husband observed that she had developed some habits such as shaking her legs and biting her nails, especially when she was out of his home

or traveling. However, when he brought it up and asked her about it, she became defensive and denied it, seemingly unaware of these behaviors. As this behavior continued and the patient consistently denied it, the husband came to understand and stopped asking further questions. While it occurred multiple times, he didn't give too much attention to it, as he believed his wife's explanations.

The patient initially sought medication for her anxiety from her gynecologist due to difficulties with traveling and leaving her house. However, because of her pregnancy, she was unable to take anti-anxiety medication and was referred to the Clinical Psychology Unit for psychotherapy.

Psychological assessment- Prior to starting therapy, a psychometric assessment was conducted to measure her intellectual functioning and symptoms of social anxiety. Before beginning psychotherapeutic intervention, the patient underwent a psychometric assessment to evaluate her cognitive and emotional functioning. The IQ test results revealed that she had an average level of intellectual functioning (Grade III, 25th-50th percentile). Her anxiety symptoms were also assessed using the Hamilton Anxiety Scale (HAM-A), with a score of 20 indicating mild to moderate anxiety. The Severity Measure for Social Anxiety Disorder (Social Phobia) utilising the Social Phobia Inventory (Liebowitz, 2002) was used to assess her symptoms of social anxiety disorder further. The questionnaire assessed the patient's level of anxiety by measuring fear, phobic avoidance, and autonomic symptoms associated with social anxiety disorder. These evaluations aided the healthcare professional in developing a suitable treatment plan for the patient's requirements.

Thus, a diagnosis of (F- F40.1) was made with the following case formulation:

Predisposing Factor	Precipitating Factor	Perpetuating Factor	Protective Factor
• Age	• Pregnancy	• Easily tensed in face of social situation	• Adherence to therapy
• Introvert	• Stress		
• Sensitive to negative evaluation		• Low self esteem • Increased health concern	• Supportive Husband

Process of Therapy

The patient's social anxiety disorder was treated using cognitive-behavioral therapy (CBT), an effective and evidence-based approach that targets negative thinking and behavioral patterns in social situations. The patient underwent a 15-week course of CBT consisting of 12 sessions, each lasting between 1-1.5 hours. The primary goal of the therapy was to modify the patient's thinking and behavior

in social situations, achieved through a collaborative approach utilizing different behavioral and cognitive techniques.

S. No.	Sessions	This session incorporates the following intervention
1	Psychoeducation	The patient and her spouse were educated about the illness, its symptoms, and probable causes.
2	Goal Setting or Begin Intervention Techniques.	The therapist helped the patient set daily goals by implementing scheduling techniques and behavioral activation.
3	Continue Intervention Techniques	The therapist continued the intervention by tracking progress and identifying negative thoughts and core beliefs.
4	Continue Intervention Techniques	Introduced deep breathing exercises as a relaxation technique.
5	Refine Intervention Techniques	Refined the intervention techniques as in vivo exposure was used to gradually expose the patient to feared situations.
6	Refine Intervention Techniques	Refined the intervention techniques as in vitro exposure was used to gradually expose the patient to feared situations.
7-8	Continue Intervention Techniques	Social skills training was introduced in sessions
9-10	Continue behavioral intervention	The patient practiced communication skills to improve her social skills and confidence.
11	Discuss Ending Treatment and Prepare Maintaining Changes	The therapist discussed ending the treatment and helped the patient prepare to maintain changes.
12	Maintenance and relapse prevention	End-of-treatment planning involves collaborative preparation of the patient to maintain progress, avoid relapse, and use acquired skills to manage anxiety effectively.

Session 1. Psychoeducation: In the initial sessions, a rapport was established and they were assured of confidentiality. Thereafter, the patient and spouse were psychoeducated about the illness and the probable causes that may trigger it. Problems faced by her traveling and social situation were discussed. The expectations of the patient from the therapy were discussed. They were made aware about the therapeutic procedure and its essential requirements like the importance of sincerely doing the tasks assigned in order to bring about the desired changes. Both the patient and her spouse understood the mechanism of illness

and agreed to follow the psychotherapeutic management in collaboration with the therapist. The therapist provides information about social anxiety disorder, its symptoms, causes, and how it affects people's lives.

Session 2. Goal Setting Or Begin Intervention Techniques.

The main goal of the second session was to structure the patient's daily activities by implementing scheduling techniques. Behavioral activation was used to encourage the patient to engage in activities that could improve her mood and overall functionality. The first step involved creating a schedule that allowed the patient to allocate more time to healthy behaviors and less time on her mobile devices. However, the patient had difficulty adhering to health-related guidelines recommended by her gynecologist. Therefore, a schedule was developed with the patient's input, including her interests such as using social media platforms like Instagram and YouTube, while focusing primarily on practicing pregnancy care. The schedule was realistically planned to increase the likelihood of compliance, and the patient agreed to limit her use of mobile phones and social media platforms to a specified period each day.

Session 3. Continue Intervention Techniques:-To track progress and identify negative thoughts, the patient was advised to maintain a daily diary detailing how much of the schedule she was able to follow. The husband was also instructed to objectively measure changes in her behavior, using her previous routine as a baseline. The focus was on whether the patient was adhering to healthy pregnancy practices such as taking medications and resting, as well as limiting mobile phone use. The therapist assisted the patient in recognizing and challenging maladaptive thoughts that contributed to her social anxiety. Through this process, the patient learned to replace negative thoughts with more positive and realistic ones. For instance, she frequently expressed the belief that she would never be able to enjoy traveling again following her anxiety episodes.

Session 4. **Continue Intervention Techniques.-** In this session, the patient was introduced to deep breathing exercises as a relaxation technique. Relaxation techniques are a collection of psychotherapeutic techniques that aim to reduce tension, stress, worry, and anxiety. These techniques are important in brief therapy for several reasons. Firstly, therapist help patient to develop skills to alleviate the symptoms of stress, anxiety, worry, and tension that often interfere with their daily functioning. Secondly, these symptoms can be very uncomfortable for patient, and providing help to alleviate their distress can improve their treatment expectations and outcomes.

Session 5. Refine Intervention Techniques;-The therapist proceeded to in vitro exposure in the desensitization process, where the client imagined facing feared situations, starting with short trips in an auto and gradually increasing distance and duration. Relaxation techniques and coping skills were taught and practiced during the sessions. The patient reported increased confidence and less

anxiety after each imaginal exposure. The goal was to continue with imaginal exposure sessions and work towards independent travel without anxiety or avoidance behaviors. The patient said, "I think now I am able to travel in the auto with my husband for a short distance without any stress" .

Session 6. Refine Intervention Techniques-The therapist used in vivo exposure to gradually expose patient to feared situations, starting with short rides in an auto or bus with a trusted person and gradually increasing the distance and time spent in the vehicle. The therapist provided support and positive reinforcement, which helped the patient become more comfortable and confident in traveling, expanding their social and professional opportunities. The therapist may have also provided homework assignments for the patient to continue practicing their skills outside of therapy sessions. According to the patient, "I do not feel any anxiety at all when traveling by car for a short distance." The therapist makes a list of anxiety-provoking situations ranked by difficulty to gradually expose the patient to them in a safe way, helping them develop anxiety management skills.

Session 7-8. Continue Intervention Techniques- In this session, the therapist focused on social skills training for the client to educate her how it works and she had to practice the behavior per day . Social skills training can be beneficial for clients with anxiety, fear of public speaking, and other similar issues, as it can help improve their overall functioning in social situations. At this point, the child explained how worrying about traveling and meeting people in crowds terrified her of negative beliefs like "I won't be able to interact appropriately with the people" which in turn lead to sweating and hot flashes.

Session 9-10. **Continue Behavioral Intervention-** In this session, Therapist ask patient for daily practice of communication skills to improve social skills and confidence. Struggle areas were identified, and techniques were taught through role-play activities. Patient overcame anxiety and gained confidence in social situations. The therapy had a positive impact on the client's social skills, allowing her to make new friends and attend a family function. This can lead to better social functioning and quality of life. After several weeks of practice, the client reported feeling more comfortable and confident in social situations. She shared, "*ab mujhe sabke samne aane me der nahi lagta kyon ki pregnancy ek normal cheez hai usme koi ajeeb lagne wali baat nahi hai*". The therapy had a positive impact on her social skills and ability to make new friends.

Session 11.Discuss Ending Treatment and Prepare Maintaining Changes- The patient and her spouse expressed satisfaction with the positive outcome of therapy, as she was able to attend a family function without experiencing anxiety. Although initially she felt the urge to flee, she was able to manage her anxiety and reported feeling less anxious than during a previous event due to practicing relaxation exercises and gaining confidence. The therapist acknowledged and appreciated the progress made by the patient and her spouse.

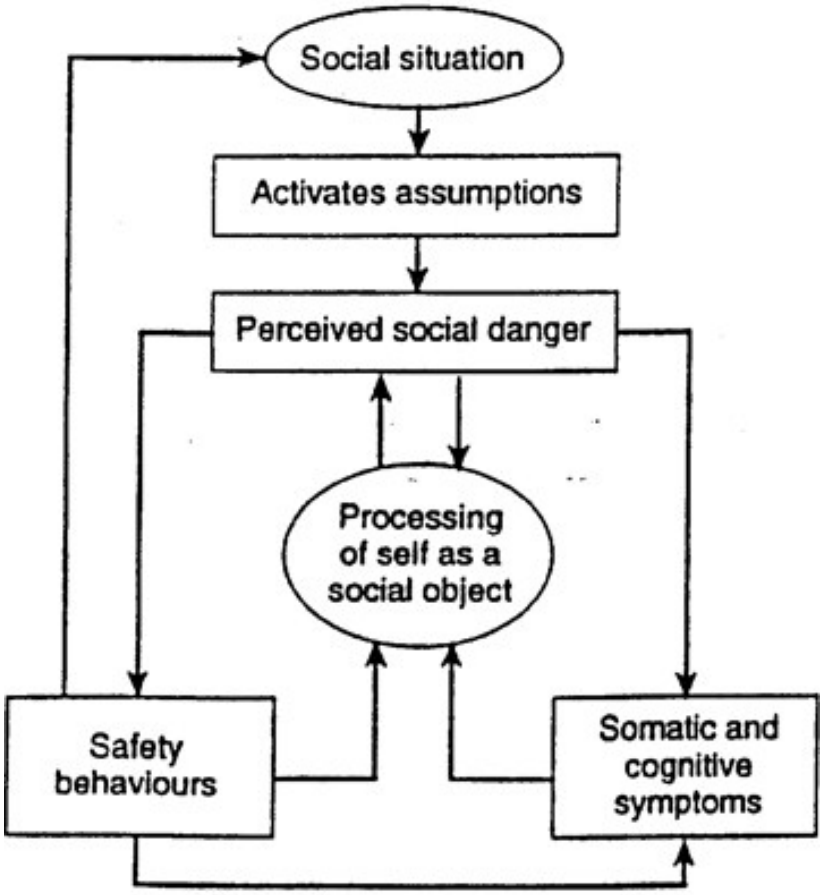
They informed the therapist that they were going on a trip to their hometown, and agreed to continue therapy sessions upon their return. Prior to the break, the patient's HAM-A score was 8, indicating a significant reduction in anxiety symptoms. At the end of 11 sessions, the patient showed increased compliance in practicing healthy behaviors, reduced overall anxiety, decreased mobile usage, and increased self-confidence. Future plans include helping the patient maintain abstinence and prevent relapse.

Session 12.-Maintenance and relapse prevention: -The therapist assists the patient in developing a plan to maintain their progress and avoid relapse, while the client learns to identify early signs of anxiety and use the skills they acquired in therapy to manage their anxiety effectively. End-of-treatment planning involves collaborative preparation of the patient and assessment of her readiness for discontinuing treatment and moving towards independent use of the acquired skills. The planning process enables the patient to anticipate the end of treatment, review the skills learned in therapy, and discuss and problem-solve any concerns about functioning outside of treatment. To apply these skills in daily life, the client is given homework assignments.

Discussion – According to research, Social Anxiety Disorder (SAD) is a prevalent mental health condition among adults in India, with higher susceptibility among women than men (Jaisoorya et al., 2017). SAD is marked by intense fear, nervousness, and self-consciousness in social situations, resulting in avoidance or enduring social situations with intense fear or anxiety.

To develop an effective treatment plan for the patient, a comprehensive assessment was conducted using a model that considers various factors contributing to her condition, including personality traits, life events, and coping strategies. Based on her symptoms, the patient was diagnosed with SAD (F40.1), and cognitive-behavioral therapy was recommended as an effective treatment option. Cognitive-behavioral therapy involves techniques such as education, goal-setting, behavioral activation, relaxation, exposure, and social skills training to help the patient manage their anxiety and improve their overall functioning (Hofmann, Asnaani, & Hinton, 2010). The therapist follows the cognitive model developed by Clark & Wells (1995) and Clark (2001) to assist the patient in managing their social phobia.

The cognitive model explains why social anxiety disorder symptoms persist despite repeated exposure to social situations. It argues that negative attitudes and assumptions cause negative self-evaluation and the belief that others are judging them negatively, which leads to self-observation and physical sensation monitoring. Individuals suffering from social anxiety disorder may correlate internal information with anxious sensations, resulting in vivid or inaccurate images from the perspective of an observer, and safety behaviours can hinder disconfirmation of the expected outcome, producing even greater distress.



Cognitive Behavioral Model Of Social Phobia (Clark, Wells, 1995) Figure taken from-Nordahl, &Wells, (2022). CBT for Social Anxiety Disorder. doi:10.1017/9781108355605.008

The third element that contributes to the persistence of social anxiety disorder symptoms is anticipatory and post-event processing, which occurs when individuals focus on their feelings and develop negative self-images associated to social encounters, as well as selectively recall past failures. CBT has been found to be an effective treatment for social anxiety disorder, and the therapy techniques used in this case, such as psycho-education, relaxation techniques, exposure therapy, and cognitive restructuring, were effective in reducing anxiety and improving the patient's self-perception and way of thinking. These findings are consistent with previous research, including that of David (2004).

CBT with exposure and cognitive restructuring has been consistently found to be effective in treating social anxiety disorder in various studies, including meta-

analyses by Hofmann et al. (2012) and Wheat et al. (2010), as well as a randomized controlled trial by Dimidjian et al. (2011). These studies support the use of evidence-based treatments, including relaxation techniques and behavioral activation techniques, for managing social anxiety symptoms.

Conclusion

The case study provides a comprehensive overview of social anxiety disorder and its treatment options. It highlights the cognitive-behavioral model of social phobia and the therapy process involved in treating SAD. The article emphasizes the importance of evidence-based treatments such as cognitive-behavioral therapy, relaxation techniques, and behavioral activation techniques, which have been found to be effective in managing symptoms and improving functioning.

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DO OPPOSITES ATTRACT OR LIKE DISSOLVE LIKE? HETEROGENEITY OF FRIENDSHIP NETWORKS FORINDIAN YOUNG ADULT MALES AND FEMALES

Gulgoona Jamal

Abstract

Objective. To examine and compare the heterogeneity of "friendship network" of Indian young adult males and females.

Method. The sample consisted of two groups of young adult males (n = 35) and females (n = 35)with age between 18 to 25 years. The measure comprised of items adapted from research done on friendship network by van der Horst and Coffe (2012), and included questions regarding ethnicity, mother tongue, sex, income level, educational level, and age of participants' friends.

Results. Except for income level, where males showed significantly greater heterogeneity than females, the two groups did not exhibit significant differences on the heterogeneity of "friendship network". Despite the insignificant differences, males showed greater heterogeneity and females showed greater homogeneity in their "friendship network".

Conclusion. The present study has shown that Indian young adult males and females showed an amalgamation of heterogeneity and homogeneity in their "friendship network" with males showing a tilt towards heterogeneity and females towards homogeneity.

Keywords: Friendship network, assortative matching theory, aversion to heterogeneity, Social identity

Literature and folklore across eras and places are abound with stories of exemplary friendships that exude virtues like joy, togetherness, support, selfless love, care, and sacrifice. Friendship indeed is a quality that sets humans apart from the rest of the species on this earth. Such a precious quality must entail some scientific process in its acquisition and maintenance. How do people make

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friends and develop "friendship networks"? Can principles of physical sciences like "opposites attract" or "like dissolve like" explain this phenomenon? A common notion regarding choice of friends is that "opposites attract", i.e., dissimilar individuals are more likely to become friends. However, research has found greater evidence for "like dissolve like" (a principle in the field of chemistry which implies that the elements with similar properties can act as solvents for each other). This principle can be used to explain the underlying reasons for people's preferences when they form interpersonal relations, such as "friendship networks". Several researchers, such as Kalmijn (1994), Domingue et al. (2014), Monaghan (2015) have suggestedBecker's (1973) "assortative matching theory" to answer the question as to why people prefer to befriend certain individuals over others. The "assortative matching theory" says that people prefer to strike friendship with those individuals who are homogeneous with themselves in various attributes like gender, age, ethnicity, mother tongue, religion, educational and socioeconomic status. Such a preference helps people to maximize the benefits of friendship networks. As Becker (1973) has talked about the "optimal matching" in matrimonial relationships where two people with highest "qualities" attract each other, thus resulting in a relationship that is based on homogeneous "qualities". Taking the cue from Becker's explanation, Churchill and Smyth (2020) have suggested that in the context of friendship networks, cultural resources can be viewed as the "qualities" which are shared by the individuals through ethnicity, religion, age, gender, mother tongue, etc. According to Kalmijn (1994), these qualities contribute to shape people's cognitions and behaviours about arts, culture, politics, policies, and thereby influence their interpersonal relationships, social identity, social confirmation, etc. by forming a perception of sameness. This perception makes them view each other as sharing the same qualities which helps to form a "friendship network". Hence, as suggested by Kandel (1978), through "assortative matching", people purposefully select those individuals as friends with whom they share the same or similar qualities. Having peoplesimilar to oneself as friends has several benefits. For example, facilitation of communication, conflict reduction, validation of self-worth, increased mutual trust, strong social identity, and enhanced self-esteem (Newcomb, 1956; Laursen, Hartup, &Koplas, 1996; Becker, 2013; McPherson et al., 2001; Chen & Li, 2009).

Sharing similar background in terms of ethnicity, religion, gender, age, education, and socioeconomic status reduces communication gaps and facilitates communication which reduces the chances of conflict. Effective, amicable communication provides opportunities for social affirmation of one's views and behaviours which verifies one's self-worth. Interestingly, people not only select similar people as friends but also deselect dissimilar people to avoid tensions, conflicts, and divisions in their friendship networks. This selection-deselection process can be explained through assortative matching theory, where people tend

to mutually choose each other based on shared qualities and leave the friends who are seen as dissimilar because according to Poulin and Boivin (2000), they perceive the former as rewarding, whereas the latter as an unrewarding situation. Another explanation provided by Alesina and La Ferrara (2002) is the "aversion to heterogeneity". It says that there is a trust deficit among dissimilar people. Fear of dishonesty and betrayal leads people to avoid heterogeneity in their friendship networks (Glaeser et al., 2000). Further, according to Letki (2008), heterogeneous communities have low levels of interpersonal trust. On the other hand, homogeneity encourages the sharing of opinions, preferences, activities and thus increases social cohesion, which helps in group formation and group membership. Group membership provides social identity, which can be defined as a sense of self that one derives from being a group member. Since friendship networks are also cohesive groups with friends sharing same/similar qualities being members, these networks provide an important source of social identity for an individual. Based on social identity, members of a friendship network identify themselves as the "in-group" and those outside their network as the "out-group". These explanatory theories suggest that friendship networks are more likely to be homogeneous than heterogenous. Several research studies have supported this premise, for example, research by Churchill and Smyth (2020) and van der Horst and Coffehas found friendship networks to be ethnically and religiously more homogeneous.

Doubtlessly, these studies have valuably contributed to understanding of friendship network characteristics. However, these studies have been reported from the Western world. An intensive review of literature found some Indian studies in this area (e.g., Falki& Khatoon, 2016) but none of these have studied the heterogeneity of friendship networks in the Indian context. This is surprising as India being a land of diversities at multiple levels, such as ethnicities, religions, languages, cultures, it will not only be interesting but will be academically and socially significant to examine the friendship network composition in Indian population. Therefore, the present research has been conducted with an objective to examine the friendship network composition among Indian male and female young adults. Based on the existing research, it has been hypothesized that a greater homogeneity than heterogeneity will be found in the friendship networks for both Indian male as well as female young adults.

Method

Design

A cross-sectional research design with Indian young adult males and females were included as separate groups. The respondents were administered measures of demographic information and friendship network characteristics.

Participants

Through snowballing technique, Indian young adults with age between 18 to 25 years were contacted. Initially, 84 young adults (Males=39, Females=45) consented to participate in the study. The criteria of inclusion consisted of age range of 18 to 25 years, Indian citizens, having functional two parent families, residing in urban areas of India,with a working knowledge of English. The criteria of exclusion were being in a romantic relationship, being married, being a single child, residing outside India, and presence of any diagnosed physiological or psychological disorder. Following the inclusion and exclusion criteria, the sample for the present study consisted of 70Indian youngadults (Males=35, Females=35) of age between 18-25 years.

Measures

Measure of Demographic Information: It included questions about the participant's age, gender, family structure, number of siblings, rural/urban residence, socioeconomic status.

Measure of friendship network: A questionnaire was devised based on the research conducted by van der Horst and Coffee (2012) on friendship network characteristics. The domains on which "heterogeneity," of the friendship network was assessed, were viz., ethnicity, mother tongue, sex, family income, level of education, and age of friends. The questions were asked in terms of one's visible similarity and differences from the friends. For example, in case of ethnicity, a question was asked, *"How many of your friends are of a visibly different ethnicity from yourself?"*. The scores ranged from 0 to 1 with mean taken as 0.The scores below zero indicated homogeneity with lower the score greater the homogeneity, whereas the scores above zero indicated heterogeneity with higher the score, greater the heterogeneity. A score of 0 indicated equal number of similar and dissimilar friends, +1 indicated complete heterogeneity and -1 complete homogeneity in the "friendship network".

Procedure

Indian young adultmales and females were contacted through offline and online platforms to inform them about the conduction of a study on "friendship networks" and they were requested to participate in the study. Google forms were used to send them a description of the study and the forms of informed consent. Those who consented to participate were sent the measures of demographic information and the "friendship network" composition. Participants' queries were addressed, and they were duly thanked for participation in the present research.

Results

The present research examined and compared the difference between Indian male and female young adults on heterogeneity of "friendship network"

composition. The measurecomprised of items adapted from research done on friendship network by van der Horst and Coffe (2012), and included questions regarding ethnicity, mother tongue, sex, income level, educational level, and age of participants' friends. To examine the difference between Indian male and female young adults on "friendship network"composition, t-independent test was used.SPSS version 21 (Statistical Package for Social Sciences) was used to statistically analyze the data.

The scores above zero indicate heterogeneity where greater the score above zero greater is the heterogeneity whereas the scores below zero indicate homogeneity where lower the scores below zero greater is the homogeneity in the "friendship network". It is evident from Table 1 that males had more heterogeneous "friendship network" as compared to females who showed more homogeneous network. In case of males, the greatest heterogeneity was found for income level followed by sex of the friends which was followed by mother tongue, ethnicity, education, and age of the friends in the decreasing order of heterogeneity. Thus, males showed highest and lowest heterogeneity for income and age, respectively. On the other hand, females showed greatest homogeneity for income and education (where both obtained same scores) followed by mother tongue, sex, and age in the decreasing order of homogeneity (Figure 1).The only exception was ethnicity where heterogeneity was shown. Thus, females showed highest homogeneity for income and education and lowest for age.

Table 1. Difference between Indian young adult males and females on friendship network composition

Measures	Males (n=35) M (SD)	Females (n=35) M (SD)	t (68)
Heterogeneity of the friendship network			
Ethnicity	0.09(1.15)	.002 (0.94)	0.74*(ns)*
Mother tongue	0.13 (0.16)	-0.18 (.16)	0.18*(ns)*
Sex	0.21 (0.98)	-0.17 (0.92)	0.10*(ns)*
Income level	0.30 (1.07)	-0.25 (0.81)	0.02*
Education level	0.07 (0.90)	-0.25 (.84)	0.14*(ns)*
Age group	0.04 (0.66)	-0.05 (1.24)	0.72*(ns)*

Note: *p<0.05; ns = "non-significant"

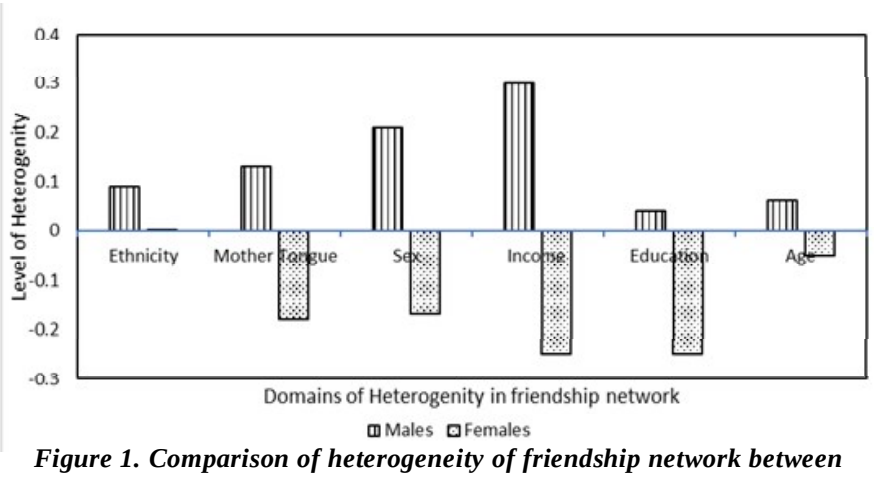

Figure 1. Comparison of heterogeneity of friendship network between Indian young adult males and females

Though, males in comparison to females showed greater heterogeneity in their "friendship network", however, their scores revealed that the level of heterogeneity was much below 1 that is indicative of lower heterogeneity. Hence, it can be inferred that males and females did not differ much on heterogeneity of their "friendship network". This was corroborated by further statisticalanalysis of the scores with independent-t test which did not reveal significant differences between males and females for their friendship network for ethnicity, mother tongue, sex, education, and age. However, a significant difference was found between males and females only for income level, where males showed the highest level of heterogeneity whereas females showed highest level of homogeneity (Table 1).

Discussion

The present study examined and compared the heterogeneity of "friendship network" for Indian male and female young adults. The results revealed thatmales and females did not differ significantly on most of the domains of "friendship network", viz. ethnicity, mother tongue, sex, education, and age. The only exception was the income level, where males showed significantly greater heterogeneity than females. Though, males showed slightly greater heterogeneity than females in their "friendship network", however, none of the scores obtained were near the value of +1 which was indicative of complete heterogeneity. Similarly, females showed slightly greater homogeneity than their counterparts, but none of the scores obtained were near the value of -1 which was indicative of complete homogeneity (van der Horst & Coffee, 2012). Thus, it can be suggested that both males and females showed an admixture of heterogeneity and homogeneity in their "friendship network".

The present findings can be explained through the theory of "assortative matching" (Becker, 1973) which says that similar qualities play an important role

in choice of friends. That is people prefer those individuals as friends who share qualities with themselves. Having similar individuals as friends ensureseffective communication which reduces the chances of conflict among groups. Shared cognitions, emotions, and behaviors provide verification for oneself which leads to mutual trust. Effective communication, reduced conflict, self-verification, and mutual trust increases social cohesion culminating into cohesive groups. Membership of such groups leads individuals to perceive themselves as the part of "in-group" and others as "out-group". The individuals draw their social identity from the perception of being the member of the "in-group"(Newcomb, 1956; Laursen, Hartup, &Koplas, 1996; McPherson et al., 2001; Chen & Li, 2009). Since, "friendship networks" are also social groups hence greater the cohesion more rewarding the membership of such networks would be. Thus, people prefer more homogeneous than heterogeneous "friendship networks".

The present study will be incomplete without the mention of gender differences. Though most of these differences were insignificant, nevertheless call for an explanation.Researchers such as Costa et al. (2001) have reported that in comparison to men not only women are less open to new ideas but according to Weber and colleagues (2002) are also averse to risk taking behaviour. Hypervigilance for any possible risk in the environment may lead to overly cautious behaviour in females, for example, they may be wary of interacting with different or dissimilarpeople.Tifferet (2019) hassuggested that probability of actual physical danger in offline settings may make females more heedful of their privacy and threats. Such cautions could extend to other domains of interactions such as online settings, for example, Fogel and Nehmad (2009) have reported that females engage in more privacy settings during their online interactions. Based on these research findings, it can be suggested that females' preference for more homogeneous "friendship network" can be seen as a type of safety behaviour. It helps them to avoid taxing social situations like mistrust, communication gaps, conflict, physical and psychological risks, and ensures a "friendship network" that is more rewarding to them.

Last but not the least, the findings revealed that not only males showed heterogeneity for ethnicity but even females who had shown greater homogeneity across all the other domains showed heterogeneity for ethnicity. This is interesting as well as a positive finding given the ethnic, cultural, regional, and religious fault lines existing in a diverse country like India. Despite such diversity, Indian young adults' preference for ethnically heterogeneous friends is an indication of a healthy society that celebrates its diversity.

Conclusion

The present study has shown that Indian male and female young adults showed an amalgamation of heterogeneity and homogeneity in their "friendship network" with males showing a tilt towards heterogeneity and females towards

homogeneity.These findings are partially in line with the existing research evidence which has shown that though most people prefer homogeneous "friendship network" (e.g., Churchill & Smyth, 2020) but females may prefer it more than others as explained by researchers (e.g., Costa et al., 2001; Weber et al., 2002; Tifferet, 2019).

Limitations and Implications

The present study had several limitations, such as, a small sample size that was limited to only young adult males and females from urban milieu, belonging to medium socioeconomic status with educational status at least up to graduation. The online friendship networks were not included in the study though it could have more significance as people were forced to connect online due to COVID-19 protocol. Religion was not included, which acts as a powerful glue for social cohesiveness. A qualitative research methodology with a qualitative technique like interview, interpretative phenomenological analysis could have enabled a more in-depth study of the topic. Nevertheless, the study has important academic and social inferences as not much work has been done in this area in the Indian context. India being a land of diverse cultures, ethnicities, religions, dialects, and languages, understanding the factors that may enhance interpersonal relations, like friendship networks among people could play an interventional role to build a united and a stronger nation.

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SOCIAL RELATIONSHIP VIS-À-VIS HEALTH AND WELLBEING

Swaha Bhattacharya[1] and Piyali Roy[2]

Abstract

Each and everybody belong to society.Society is the part of the environment. Society is a collection of individuals united by certain relations or modes of behaviour. Society is viewed as web of social relationships, which are invisible and abstract. Social relationships are fundamental to human survival and are significantly involved in the attainment and maintenance of good health and wellbeing. Mental Health is the foundation for wellbeing and effective function for an individual or for a community. Good social relationship is positively associated with both mental and physical health, which creates impact upon individuals in each and every moment. Appropriate systems and support from different corners of the society is required for maintaining good physical and mental health.

Keywords: Society, social relationships, social interactions, health and wellbeing

Society

Society is a collection of individuals united by certain relations or modes of behaviour. Society and the individual are inherently connected, and each depends on the other. Integration and interaction among social groups are also essential for the survival of society. Society is the part of the environment. Each and everybody belong to society. Society makes communication to discover, evolve, create, manifest and manipulate the rules and regulations. Social factors create significant impact upon physical and mental health of human being. Human beings are closely related to his/her social environment. They always try to identify themselves with their social group or the society in which they live. Human social environments encompass the immediate physical surroundings, social

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relationships, and cultural milieus within which defined groups of people function and interact. Social environments are dynamic and change over time as the result of both internal and external forces (Barnett & Casper, 2001). The basic nature of society is dynamic and changeable. No society is static. Every society is always in a state of continuous change. Old customs, traditions, folkways, mores, values and institutions got changed and new customs and valves takes place. If society is viewed as web of social relationships, it is distinct from physical entity which individual can see and perceive through senses. Social relationships are invisible and abstract. Human beingscan just realize them but cannot see or touch them. Therefore, society is abstract. Society is a permanent institution. Its exact origin is unknown to history. It emerged from the original instincts of man and continues to exist till the existence of man. It is not a mere structure. It refers to the whole system of social relationships. It rests on the state of mind of individuals who comprise society.

Community

A community may be understood by a social group of individuals belonging to a specified area with common geography, culture, government or personal characteristics. It is thus a space, where individuals thrive, and may be considered as a shared institution and a social system, having certain values, interactive elements, power dynamics and the like. It is experienced differently by people with diverse backgrounds. Community defined as the process of working collaboratively with and for groups of people affiliated by geographical proximity, special interest, or similar situations to address issues affecting the well-being of those people (Jorm, 2000; Perkins et. al., 1990).A healthy community has well-connected, interdependent sectors that share responsibility for recognizing and resolving problems and enhancing its well-being.

Social Relationship

Social relationships are fundamental to human survival and are significantly involved in the attainment and maintenance of good health and wellbeing. A social relationship is any voluntary or involuntary interpersonal link between two or more people, individually or within/between groups. Social relationships are the basic analytical construct used in the social sciences and are central to sociology. Socialization refers to the process through which people learn the attitudes, values, and actions appropriate for members of a particular culture. Social relations are broadly defined as any relationship or interaction between two or more individuals. It includes the concepts of social integration, or level of involvement in relationships, such as marriage or group membership, and the emotional, tangible, or practical support from others that serve a functional purpose. An individual's acknowledgment or fulfillment of social roles may beneficially influence self-esteem and provide a sense of meaning or controllability to life. It is also important

to consider the converse, or social conflict, as there are important consequences to emotional and physical health for the socially isolated individual, one who lacks social connections, or those for whom relationships serve as a source of stress.

The term social relationships encompasses a wide variety of aspects relating to the proximal and distal social environment. Distal environment includes the broader social structure of opportunities for social integration (e.g. cultural, labour market, neighbourhood) and its quality (e.g. social capital) (Kawachi et. al., 2001). Proximal factors of social relationships are, namely social networks and social support. Social networks describe the size, density, frequency and duration of social contacts, whereas social support emphasizes the functional significance in terms of providing instrumental, emotional or informational resources (Cassel,1976).One of the most important tasks in human development is the ability to develop relationships with significant others. Social relationships—both quantity and quality—affect mental health and physical health. Sociologists have played a central role in establishing the link between social relationships and health outcomes, identifying explanations for this link, and discovering social variation (e.g., by gender and race) at the population level.

Health and Wellbeing

Health is the state of complete physical, mental and socialwell-being, and not merely an absence of disease or infirmity. It is a significant departure from the medical model. It is a definition of positive health and goes beyond the mere absence of a disease: the focus being on maintaining good health, rather than on the treatment of different diseases. This also makes health a multidimensional concept having four dimensions i.e. physical, mental, social, and spiritual. Health is like a dynamic field in which different elements operate in communion and harmony. Health thus refers to proper functioning of the body and the mind, as well as, the capacity to participate in social activities, performing the roles and abiding by the moral principles. It takes into consideration the nutritional status, immunity from diseases, and better quality of social and family life. The concern is not with cure i.e., treating and preventing organic malfunctioning, but with healing the person, i.e., regenerating a sense of well-being and fitness to deal with one's life conditions.

Mental Health is the foundation for wellbeing and effective function for an individual or for a community. Generally, mental health is a state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully and facing up adversity without losing the capacity to function physically, psychologically and socially. Realizing the importance and significance of the mental health for the wellbeing of the individual, different researchers have approached the term differently. Mental health is an expression of our emotions and signifies a successful adaptation to a range of

demands. Mental health is the balanced development of the individual's personality and emotional attitude which enable him to live harmoniously with his fellow mate. Mental health can be seen as a continuum, where an individual's mental health may have many different possible values. Mental health is a term used to describe either a level of cognitive or emotional wellbeing or an absence of a mental disorder. A person's state of mental health fluctuates over time, in response to many factors including physical health, life events and environmental conditions that increase protective or risk factors. Mental wellbeing refers to a positive state of psychological and emotional health; it indicates that a person is able to function cognitively and emotionally in a manner that is productive and fulfilling. Wellbeing is a multi-dimensional construct (Seligman, 2012) that involves more than just being in a good mood or feeling happy.

Well-being comprises people's evaluations, both affective and cognitive of their lives (Diener & Suh, 1997). It is an outcome of a complex array of biological, socio-cultural, psychological, economic and spiritual factors. The conceptualization of the state of well-being is closer to the concept of mental health and happiness, life satisfaction and actualization of one's full potential. Verma et al. (1989) have defined general well-being as the subjective feeling of contentment, happiness, satisfaction with life's experiences and of one's role in the world of work, sense of achievement, utility, belongingness, and no distress, dissatisfaction or worry, etc.Well-being is a positive outcome that is meaningful for people and for many sectors of society, because it tells us that people perceive that their lives are going well. Good living conditions (e.g., housing, employment) are fundamental to well-being. Well-being generally includes global judgments of life satisfaction and feelings ranging from depression to joy. In addition to positive emotions, wellbeing is achieved through optimal development, a 'meaningful' life, and satisfaction of basic human needs for autonomy, competence and relatedness (Ryan and Deci, 2001). Life satisfaction is one of the important factor in the general construct of subjective well-being. It also serves as an indicator of one's life quality and an important parameter to measure people's life quality. Life satisfaction is influenced by personal and social characteristics.In particular, life satisfaction, referring to a holistic evaluation of the person's own life (Pavot and Diener 1993; Peterson et al. 2005), concerns the cognitive component of the subjective well-being. Another commonly used measure for subjective well-being is happiness (Diener 2006), often used interchangeably with life satisfaction. Social relationships are the key players in affirming an individual's sense of self, satisfy the basic human need for belongingness (Deci and Ryan, 2002) and are a source of positive affirmation. The levels of subjective well-being increase with the number of people an individual can trust and confide in and with whom he or she can discuss problems or important matters. The presence of social relationships has positive impacts on mental and physical health, contributing to an individual's general well-

being, whereas the absence of social relationships increases an individual's susceptibility to psychological distress (Campbell 1981; Nguyen et al. 2015).

Social Interaction and Health

Social interaction is recognized as an important daily activity. It has been found in the study that maintaining social connections and having regular social interactions — like meeting friends and relatives — can actually reduce the risk of depression, and also impact the mood in a positive manner. Four important aspects of social interaction are:

Social contact- without social contact interaction is not possible. Social contact exists whenthere is reciprocal response and an inner adjustment of behaviour to the action of others.

Communication – communication in some form is essential to social interaction, without communication people cannot react to one another. Communication refers to all of which communicate a message and meaning, the means may be verbal, non-verbal, written or non-written.

Social structure – the concept of social interaction is the structure of the society, be it rural or urban. Such a structure involves social norms, roles, status and values which determine behaviour during interaction or specify the rules of the game.

Forms of interaction – social interaction may express itself in several types or forms as man interacts in different ways with others in society. Social interaction which assumes a repetitive pattern in a specific direction becomes a social process. Social processes then refer to repetitive forms of behaviour which are commonly found in social life.

People behave differently in the presence of other persons. When the shared understanding is lacking in social interaction, interaction produces surprise, disgust, anger or other disruptive feelings. Social connectedness influences our minds, bodies, and behaviors—all of which influence our health and life expectancy. Research shows that social connectedness can lead to longer life, better health, and improved well-being (Holt-Lunstad et al. 2010).

Several psychological theories have proposed that to belong and to be affiliated are fundamental psychological needs of human beings. For example, the belongingness hypothesis proposes that the need to belong is a pervasive drive that motivates human beings to form at least a minimum quantity and quality of interpersonal relationships and that failure to satisfy this fundamental need has a detrimental impact on well-being (Baumeister & Leary, 1995). Engaging in social interactions promotes well-being throughout adulthood and into old age, including state-level positive affect, negative affect and life satisfaction (Sandstrom & Dunn, 2014; Sun et al., 2020).

Social Relationships and Health

Many types of scientific evidence show that involvement in social relationships benefits health. Several recent review articles provide consistent and compelling evidence linking a low quantity or quality of social ties with a host of conditions, including development and progression of cardiovascular disease, recurrent myocardial infarction, atherosclerosis, autonomic dysregulation, high blood pressure, cancer and delayed cancer recovery, and slower wound healing (Ertel et al. 2009; Everson-Rose &Lewis 2005; Robles &Kiecolt-Glaser 2003; Uchino 2006). Poor quality and low quantity of social ties have also been associated with inflammatory biomarkers and impaired immune function, factors associated with adverse health outcomes and mortality (Kiecolt-Glaser et al. 2002; Robles &Kiecolt-Glaser 2003). Strong ties with families and friends have been found to improve mental and physical health, positively influence health behaviors, reduce mortality risk. Additionally, supportive relationships have been linked to the provision of emotional security.Social integration may directly and positively influence health behaviors. Integration also promotes social embeddedness, defined as ongoing social connectedness that facilitates beneficence toward self and others, which may positively affect health (Burt et al. 1987).

Portes (1998) defined social capital as "the ability of actors to secure benefits by virtue of their membership in social networks or other social structures," The term "network" is used to describe the ties and social relationships in which an individual is embedded. A network is composed of a finite set of actors and the relations among them. Social relationships form a resource pool for an individual. These resources can take several forms, such as access to useful information, company (e.g., personal and intimate relationships, time spent talking together, and shared amusement time or meals), and emotional (e.g., advice about a serious personal or family matter) and instrumental (e.g., economic aid, administrative procedures, house-keeping) support. In a wider perspective, social relationships serve as buffers that diminish the negative consequences of stressful life events, such as bereavement, rape, job loss, and illness (Myers, 2000).

People with close social relationships tend to report higher levels of well-being and flourishing (Diener & Seligman, 2002; Myers, 2015; Diener et al., 2018). Perceived social support affects the way people perceive themselves and the world around them. A meta-analysis indicates that not having a network of meaningful relationships in life is more predictive of mortality than other lifestyle behaviors, such as smoking or physical activity (Holt-Lunstad& Smith, 2012). *Social support* refers to the emotionally sustaining qualities of relationships (e.g., a sense that one is loved, cared for, and listened to).Social support is exceptionally important for maintaining good physical and mental health. Overall, it appears that positive social support of high quality can enhance resilience to stress, help to protect against developing trauma-related psychopathology, decrease the

functional consequences of trauma-induced disorders, such as Post Traumatic Stress Disorder (PTSD), and reduce medical morbidity and mortality. Psychological resilience represents a process of adapting well in the face of adversity. Hundreds of studies establish that social support benefits mental and physical health (Cohen 2004; Uchino 2004). Social support may have indirect effects on health through enhanced mental health, by reducing the impact of stress, or by fostering a sense of meaning and purpose in life (Cohen 2004; Thoits 1995). Supportive social ties may trigger physiological sequelae (e.g., reduced blood pressure, heart rate, and stress hormones) that are beneficial to health and minimize unpleasant arousal that instigates risky behavior (Uchino, 2006). The emotional support provided by social ties enhances psychological well-being, which, in turn, may reduce the risk of unhealthy behaviors and poor physical health (Kiecolt-Glaser et al. 2002; Thoits 1995; Uchino 2004).

Overall, perceived social support is a significant predictor of life satisfaction and negative affect (Siedlecki et al., 2014; Kostak et al., 2019; Shensa et al., 2020). Specifically, emotional support has important benefits in mental health, so many studies focus on the relationship between depression and perceived social support (Kostak et al., 2019; Shensa et al., 2020). Perceived social support and social bonds are positively related to mental and physical health (Cohen& Janicki-Deverts, 2009; Umberson& Karas Montez, 2010). Research points to a positive association between perceived social support and psychological well-being, which allows it to be seen as a valuable protective mechanism that can improve psychological well-being by maintaining positive emotional feelings and mitigating stress (Chu et al., 2010; Thoits, 2011; Liu et al., 2014).

Social Stress and Health

While social relationships are the central source of emotional support for most people, social relationships can be extremely stressful (Walen & Lachman 2000). A widely accepted view of psychological stress defines it as the appraisal of an event as taxing or overwhelming one's resources. Social relationships that are perceived as emotionally supportive have demonstrated their potential to act as a buffer of the effects of stress. Social support makes the demands of a stressor feel more manageable, thereby buffering its impact (Cohen & Wills, 1985). Relationship stress undermines health through behavioral, psychosocial, and physiological pathways. For example, stress in relationships contributes to poor health habits in childhood, adolescence, and adulthood (Kassel et al. 2003). Stress contributes to psychological distress and physiological arousal (e.g., increased heart rate and blood pressure) that can damage health through cumulative wear and tear on physiological systems, and by leading people of all ages to engage in unhealthy behaviors (e.g., food consumption, heavy drinking, smoking) in an effort to cope with stress and reduce unpleasant arousal (Kassel et al. 2003). It may seem obvious that strained and conflicted social interactions undermine health,

but social ties may have other types of unintended negative effects on health. For example, relationships with risk-taking peers contribute to increased alcohol consumption, and having an obese spouse or friend increases personal obesity risk (Christakis &Fowler 2007; Crosnoe et al. 2004). Loneliness is a distressing feeling resulting from a discrepancy between actual and desired social connection (Perlman & Peplau, 1981). Socioeconomic status is inversely associated with loneliness (Madsen et al., 2019). Loneliness is associated with a range of adverse outcomes including poor physical and mental health (Eccles et al., 2020).

While the size of an individual's social network, or integration, may not be associated with diurnal cortisol secretion or acute stress responses, supportive relationships have been associated with more rhythmic or healthy-appearing diurnal cortisol expression profiles (Rosal et al. 2004). Alternatively, it has been noted that when one feels isolated or less integrated into social networks, the associated increased psychological stress appears to amplify physiological stress responses. Social isolation has been associated with dysregulation of diurnal cortisol expression in several studies of healthy adults (Cacioppo et al. 2000). In human studies, low social support has been associated with physiological and neuroendocrine indices of heightened stress reactivity, including elevated heart rate, increased blood pressure, and exaggerated cardiovascular and neuroendocrine responses to laboratory stressors.

The psychological effects of stress include shock, mental confusion, inefficiency, recklessness, apathy, fatigue, exhaustion, hallucination, thoughts of suicide, fear of insanity and the like. In general, those things are stressful which usually result in failure, fear, distraction, discomfort and rapid or inconsistent pacing and speed. Any threat to a fundamental need is stressful. Every new venture into the unknown, though, enjoyable and beneficial, creates some apprehension and anxiety. It is some stress that triggers the creative thinking process and keeps it going until a solution is achieved and communicated. There is an interaction between a society and its physical environment, which has a corollary: that changes in this relations will be affected by changes in the society, on the one hand, and in the environment on the other. Any given human society exist in relation to their human societies which together form its social environment. There are aspects of man-environment relationships that are substantially the same for all mankind. Any major social change is the result of multiple interacting changes among the frequently identified components of major social change are those classified as physical, perceptual, conceptual and institutional.

Conclusion

Society is the part of the environment.The quality of the environment is particularly critical to health, welfare and happiness of human being. Health, is a state of complete physical, mental and social wellbeing is a fundamental need and it is clearly related to the social environment. The effects of stress on

personality development and mental health are mainly determined by three variables: the duration of stress, the intensity of the stress and the state of the organism. Society's concepts of mental health includes conformity, well-rounded personality, equation of divergency with mental illness and delinquency, masculinity and femininity and so on. Community wellbeing means promoting the conditions of society which brings people together to get rid of different types of problems. Not only this, feeling of awareness is required to solve the problem as far as possible. As change is the part and parcel of life, individuals have to understandthe situation and to accept the responsibility for the change for the welfare of the society. Adequate measures may be taken to promote good social relationship among individuals and also to keep themselves mentally and physically healthy.

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DEVELOPMENT OF HELPING BEHAVIOUR WITH BEHAVIOUR TECHNOLOGY

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Abstract

Moral behaviours in children are essential as they teach them to develop positive traits such as kindness and compassion to act according to ones moral values and standards, children demonstrate prosocial and moral behaviour like "Helping behaviour" when they share, help, cooperate, communicate, sympathize or in otherwiswe they demonstrate ability to care about others.

Helping behaviour is specific in its nature and occurs in a social environment. Therefore, the important question for understanding the development of helping behaviour is undr what motivational situational conditions does the child help? This question implies that the social environment may play an important function in the development of "Helping Behaviour".

The present study was designed to investigate the impact of Helping Behaviour Technology in the Enhancement of Moral Development of the School Students. The sample consisted of 400 Students (200 Girls, 200 Boys) selected from various Municipal Higher Secondary Schools and Government Boys and Girls Schools of Coimbatore and Tirupur Districts. Ganesan (2007 b) Development of Helping Behaviour Technique was administrated to the respondents.

Results revealed that Tirupur District Students have significantly higher Helping Scores than the Coimbatore District Students. The parents of the Tirupur Children have the opportunity to earn more because of the busy Textile Industries. Hence the families are affuluent, which results in the development of their Children's Helping Behaviour. Tirupur District is having maximum profit in India because of the Export Potential.

Keywords: Moral behaviour, helping tendency, kindness, compassion, sympathize

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Moral Education is for fulfilling the Duties relating to Society and Nation. If a person does his/her duty honestly, it means he/she is learning Moral Education in the real sense. Kohlberg (1984) describes the child as a 'Moral Philosopher", who develops Moral Standards of his/her own; these standards do not necessarily come from parents (or) peers but emerge from the 'Cognitive Interaction' of the child with his/her Social Environment. This position is expounded in the Moral Development approach of Kohlberg (1984), whose Theory was based on that 'Cognitive Development Theory' of Piaget (1962).

Morality has to be described not as an 'External State', but rather in terms of an 'Internal State', (Kohlberg 1984 and Pittel and Mendelsohn 1996) thus in the present study, 'Behaviour Modification' program incorporates, what is typically described as 'Cognitive Skills' and 'Educational Programming' but surpasses common classroom methods as a comprehensive 'Cognitive Behavioural Training Program'.

Amareswar, (2011) reported in his article 'Inculcation of Human Values through Education with the help of Science and Technology'. He quated "Sathysai words Thinking with Love is Truth Feeling with Love is Peace, Acting with Love is Right conduct, understanding with love is Non-Violence". According the Sathya Sai Baba like Values are necessary for students – They are Right conduct, Peace, Self-discipline, etc.

His article gives note on 'Importance of Values' like in today's multicultural and multi – racial society, with its changing Social norms and Expectation, it can be difficult for a young person to know what is right. To enable young people to appreciate themselves and others, and to take greater responsibility for their actions and for the World around them. Sri Sugunendra Tirtha Swamiji of Puthiga Math (Hayavadana Acharya) (1974) has said that it is necessary to give importance to Human Values in the present Era of Globalization. Here he has emphasized that with the help of Science (Exhibitions) and Technology i.e. Print and Electronic Media and Mass Media including Social awareness Programmers we can inculcate the Values in the young people.

Shailaj Kumar (2012) studies 'Promotion of Moral Values through Education' emphasize about urgent need of Value Education in higher education Institutes. To save the whole education system as well as the human we need to address more and more fundamental issues of the social and moral consequences. He emphasized that, the Parent, Teachers and the Institutions have a definite and inevitable role to play in providing Moral Education in a Multi-Cultural Society.

The self-regulatory skill develops continuously in parallel to the structural changes in children's thinking it is possible to observe a sequence in the development of the self-regularity skill. The young child's "Helping Behavoiur" is governed, according to Mischel and Mischel (1976).

Although emotional responses such as guilt, personal distress and empathy are important determinants of altruism, it is the social situation itself-the people around us when we are deciding whether or not to help that has perhaps the most important influence on whether and when we help.

Thus, here "Helping Behaviour" is providing aid or benefit to another person. It does not matter what the motivation of the helper is, only that the recipient is assisted. This is distinguished from the more general term prosocial behavoiur, which can include any cooperative or friendly behaviour seeing other people do good things encourages and inspires others to take action to help others (Cherry, K -2004)

To make our country Incredible India, we ought to Influence our younger generations mindset with the best. We could and make them understand the importance of Moral Values to build good character. If only we inculcate the moral value which could be achieved only through education with moral science, we can glorify youth of today as the best citizen.

Thus, research on Helping Behaviour has become a major area of interest for Psychologists. However, most of the studies have concentrated on the search for personal and situational variables affecting Helping Behaviour of children and adults. The increased interest in Helping Behaviour has not established a consensus on definition. Such terms as Helping Behaviour, Prosocial Behaviour or altruism are often used interchangeably by researchers (Bar-Talo, 1982).

Helping acts differ in students' quality, in fact it is possible to classify various helping acts in accordance with their motivations on the quality dimension.

Helping Behaviour in children and adults has received considerable interest in the last few years, but the potential advantages of encouraging Helping Behaviour in young children have yet to be examined. What might children learn from helping others or from being helped by others? What significance might helping have for children, the classroom, or even society? A personal benefit to the child who helps others would be a sense of competence in assisting others. While (1960) and others have referred to a motivational disposition which is central to psychologically healthy development.

A helping act on the highest quality level is an altruistic act. An altruistic act is defined as voluntary and international behavior carried out for its own end to benefit a person, as a result of moral conviction in justice, and without expectations for external rewards.

Daniel (2014) studied "Values and Helping Behaviour" – the findings of the study states that "Values" are important factors in determining individual's behaviours. Across cultures (Germany, Scotland, UK, Israel and Turkey) the value types of self – transcendence versus self-enhancement and conversation versus openness to change were positively related to helping. Specifically, self-

transcendence values were positively related and self enhancement and openness to change values negatively relates to helping behaviour. The corrections pattern did not differ significantly between cultures.

Although many researchers believe that egoism is the only motivation for helping, others suggests that altruism-helping has as its ultimate goal, the improvement of another's welfare may also be a motivation for helping under the right circumstances.

Children can learn social and emotional skills from the time they are babies. These includes helping, sharing, comforting and cooperating. Prosocial behaviour like helping behaviour is important for developing healthy life and relationship skills and has been shown to enhance mental functioning and improve academic performance in children.

The purest forms of prosocial are motivated by altruism, an unselfish interest in helping another person. According to Santrock, the circumstances most likely to evoke altruism are empathy for an individual in need, or a close relationship between the benefactor and the recipient.

The emergence of research into Helping Behaviour can be directly traced to a number of theoretical sources: Gouldner's (1960) preposition regarding the prevalence of the universalistic norm of reciprocity; Lead's (1963) suggestion regarding the prescription of the norm of giving; Piaget's (1932) and Kohlberg's (1958, 1969) theorizing about the development of moral judgement; and Aronfreed's (1968) conceptualization of conscience development. These theories explicitly discuss social conditions for Helping Behaviour.

Thus, Helping Attitude is an established noble behaviour or the degree of concern for the welfare of the others with regards or disregards of rewards. Researches conducted in the field of Positive Psychology support that traits like Helping Attitude reflects the practice of human strength certain skills to build helping attitude in a scientific way.

Helping Attitude is a willingness and concern for the welfare of others. It refers to voluntary actions intended to help others, maybe in the actions intended to help others, maybe in the line of money or some returns or purely selfness help. In simple words, it is caring about the welfare of other people and action to help them. Helping is the function of either relatively selfish or relatively unselfish motives (Boron and Byrne -1999

However, most of the Helping Behaviour research has not developed from a particular theory but has resulted from problem–oriented research questions. Such questions as why people are often apathetic and do not help others, what conditions facilitate helping, or what personal characteristics are associated with the tendency to help have guided the study of Helping Behaviour

While moral values like "Helping Behaviour" are essential in whatever stage of life we are in, the values that most adults have are the ones that were instilled in them during our childhood. They form the fundamentals in any student's life. It is said that students are future of India and this future of our country depends greatly upon the values imparted to them during their student life. Moral values pave the path for all their decisions in life, as without these values; like helping behavoiur, etc., children do not have any guidance and life may seem to be directionless.

In the present study the "Helping Behaviour" is to be enhanced by offering Behaviour Modification Training using a Technique Developed by Ganesan, (2007 b).

Method

Aim

To study "Impact of Behaviour Technology in the Enhancement of helping behaviour" among school students in Coimbatore and Tirupur Districts.

Sample

The samples consisted of 200 Girls and 200 Boys from the various Government, Municipal Girls and Boys and Co-Educational Schools from Coimbatore and Tirupur Districts of Tamil Nadu State, India.

The sample was divided into a Control Group and an Experimental Group.

Table 1: Control and Experimental Groups

Gender	Control Group	Experimental Group
Boys	100	100
Girsl	100	100

Interventions Administered

Developing of Helping Behaviour (Ganesan, 2007 b)

When a student offers help to his/her Parents/Teachers/Others, he/she has to allot a Helping Score to himself/herself in Multiples of 1000s.

A Student can allot 3,000/5,000/10,000 for the 'Help' offered by him/her to others. This score has to be given liberally. The cumulative score has to be carried over to the next days. The score will grow day by day.

Example: Student's help to his / her mother / Father / Brother / Sister. Student's help to his / her friend financially or non financially but with physically, to others on the road or to the society.

Weekly once the Cumulative Score was appreciated by the Researcher and by the Group of Students by clapping their hands in appreciation of that Helping Behaviour.

Thus, this Cognitive Behaviour Training for Development of Helping Behaviour was given by exposing the Experimental Group to 'Real Life Situations' in order to help them to develop their Helping Behaviour.

Control Group was treated as the II Experimental Group and it was administered the same Intervention.

The Intervention was administered for seven weeks for the Experimental and II Experimental Groups.

Results and Discussion

The scores and results are presented in Table 2 and 3. The Scores and Results were obtained by using Statistical Technique like Mean, Standard Deviation, Mean Differences and Critical Ratio.

Table 2: Shows the Mean score of Helping Behaviour among both the Genders

	Mean S.D.	**Mean Difference**	**t-Value**
Girls	57.92		
(N= 200)	(3.93)		
Boys	56.63	1.29	1.59NS
(N= 200)	(5.51)		

There is no significant difference in the mean scores of Boys and Girls.

This shows that the Boys and the Girls do not differ significantly in their Helping Behaviour and there is no Gender Difference.

Table 3: Shows the Mean scores of Development of Helping Behaviour for two Districts

	Mean S.D.	**Mean Difference**	**t-Value**
Tirupur	61.43		
(N= 200)	5.65		
Coimbatore	56.24	5.19	5.45**
(N= 200)	5.51		

**$p<0.05$

There is no significant difference in the mean scores of Boys and Girls.

This shows that the Boys and the Girls do not differ significantly in their Helping Behaviour and there is no Gender Difference.

This shows that Tirupur Students have significantly more Helping Scores than the Coimbatore Students.

The parents of the Tirupur Children have the opportunity to earn more, because of the busy Ttextile Iindustries'. Hence the families are affluent, which results in the Development of their Children's Helping Behaviour. Tirupur district is having maximum profit in India because of the Export potential.

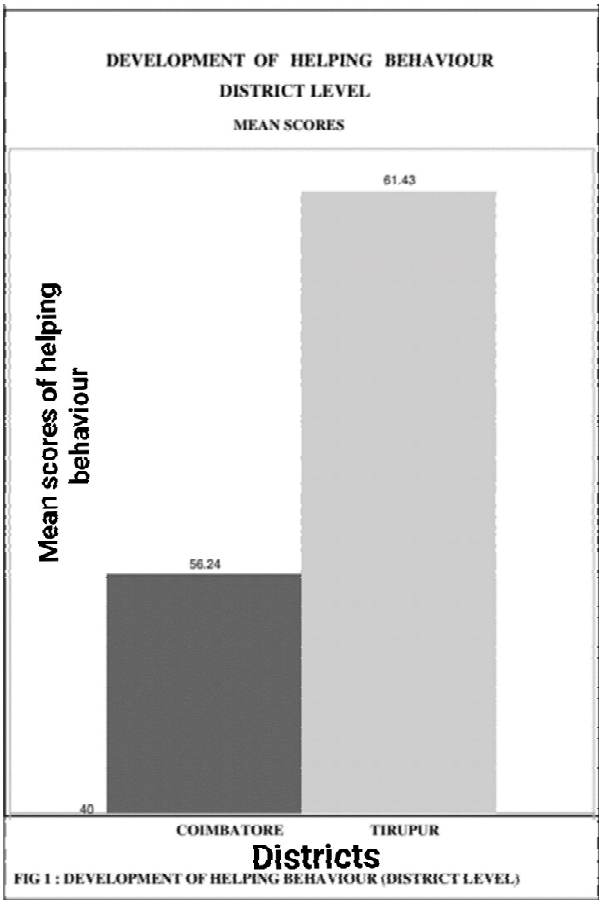

FIG 1 : DEVELOPMENT OF HELPING BEHAVIOUR (DISTRICT LEVEL)

The present study is an attempt to find out the effect of Behaviour Technology in the enhancement of Helping Behaviour among students. It also attempts give some Behavioural Training Technique for developing Helping Behaviour among school students.

Among the two groups of Students of Coimbatore and Tirupur District on the Development of Helping Behaviour, Tirupur Students have been significantly more benefited. Tirupur in TamilNâdu State in the country of India is always busy cotton City.

This shows that Parental Income is an important factor for the Development of Helping Behaviour.

Conclusion

The findings of the study confirm the concepts obtained by Raj (2009). "Gems of beautiful Values will adorn the bright and glittering personality of child". The child will be all set and prepared to face the 'Right' and 'Wrong' of the World and to eradicate all 'Evils' right from the roots. Such bold personalities will help in establishing a peaceful and prosperous World.

The findings of the study support the concepts obtained by Buragohain and Sonowal (2016). Both of them said, "Helping Attitude is the quality of individual which benefits the giver as well as the receiver and work as a strong pro-social behaviour. So, it is urgent to develop certain scientific skills to cultivate this virtue. It is discovered that the virtues and strengths of life can be significantly taught and learnt through exercises. It is further concluded that helping attitude can significantly be taught and learnt through exercises.

Social psychologists have explored individual-level explanations for why people help. Their explanations concern the rewards received and costs paid for helping and the emotions around helping. People may receive rewards for helping others. These rewards can be physical rewards, like receiving a monetary award for returning a lost wallet, a social reward, like having public recognition good deed, or emotional, like feeling good after carrying groceries for an elderly neighbor. Costs associated with groceries are also motivating. People may help others specifically to avoid the guilt and shame associated with not fulfilling social obligations. People may also fear the disapproval they would receive from others for not helping.

Social learning theory suggests that to the extend people experience these rewards for helping or costs for not helping, these are more likely to help others in the future, expecting the heat situation to have similar rewards and costs. So rewards and costs need not be immediate to influence motivation. Sometimes people help others because it will aid them with long term goals of social recognition, fulfill career aspirations, or increase the social reputation, goods, money and services that they receive in the future.

People learn which behaviours produce rewards and which bring costs, beginning with parental teaching and modeling of helpful behaviours and continuing through life as friends, coworkers and families praise or Criticize people for enacting behaviors.

For example, children who are taught to give to the poor through food drives and receive praise for doing so are more likely to continue these behaviours throughout their life.

The findings of the study also supported the Social Exchange Theory. The Social Responsibility norm is a societal rule that tells people they should help others who need help even if doing so is costly. Another norm that explains Helping Behaviour is the Reciprocity norm, which is the implicit societal rule that says people must help those who helped them.

The findings of the study confirm the concepts obtained by Sri Ramakrishna Mission Vidyalaya College of Education, Coimbatore (2009) "Great Teachers Scheme" to motivate their students. This is best Summarized by the words of Swami Vivekananda "The end of all education, training should be "Man Making

Education" and is not the amount of information that is put into one's brain and runs riot there, undigested all one's Life. We must have Life Building, Man Making, Character Making and Assimilation of Ideals".

The ancient Greeks and Chinese are not the only one concerned with helping behavoiur. Almost all world religions have some version of Golden-rule that people should treat others as they would like to be treated.

The Christian Bible promotes care of each other, the poor and the needy. It also tells the parable of Good Samaritan, Who helped a stranger in distress among the roadways. This parable has become the modern ideal model of positive helping behavoiur.

Like, Buddhism's Noble Eight-Fold Path encourages helping others through right speech, action and livelihood.

In Hinduism, kindness to all creatures is important because all creatures are manifestations of God.

Furthermore, helping to reduce other's suffering is good karma or a positive effect that a person's behavoiur has on subsequent incarnations.

It also supported the present study. That is an attempt to find out the effect of Impact of Behaviour Technology in the Enhancement of Helping Behaviour among students. It also attempts give some Behavioural Training Technique for developing Helping Behaviour among school students.

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ASSESSING FEAR AMONG ADULT USING FEAR OF COVID-19 SCALE DURING THE PANDEMIC OF COVID-19: EXPLORATORY RESEARCH

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Abstract

This study aimed to identify the level of fear of Malaysian adults during the COVID-19 pandemic, using the fear of COVID-19 Scale. 840 Malaysian adults were recruited via convenience sampling through an online platform. Sociodemographic variables and fear of COvid-19 questionnaires were administered, and correlation coefficients were assessed followed by logistic multiple regression. Results show that more than half of the respondents (53.2%) were reported to have high level of fear, with almost half of them (46.8%) at a low fear level. Generally, the study population had a slightly high fear of Covid-19, with FCV-19S scores trending slightly high (2.24 ± 0.55). Also, postgraduate students showed higher fear (2.46 ± 0.57) compared to graduates (2.28 ± 0.52, $p < 0.05$) and undergraduate (2.18 ± 0.54, $p< 0.001$). Additionally, findings indicated greater fear (2.31 ± 0.59, $p < 0.05$) among male respondents. People aged 36 to 56 years old (2.43 ± 0.57, $p < 0.001$) and adults living in rural areas (2.36 ± 0.56) recorded greater fear. Hence, this finding will facilitate the Malaysian government to come out with a more comprehensive strategies for the target groups to handle mental health issues during the season of COVID-19.

Keywords: Adults, COVID-19, FCV-19S, Fear, Malaysia

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Introduction

Coronavirus disease or better known as COVID-19, was declared as pandemic back in 11th March 2020 by World Health Organization in view of worsening situation across the globe. As of 30th April 2020, the number of cases were staggering, with 3,090,445 positive cases worldwide and 217,769 total deaths, with United States, Spain and Italy among the worst-hit. As such, many governments had to enforce lockdowns as well as strict social restrictions to curb the spread of the disease. Malaysian government, after careful deliberation, has implemented strict Movement Control Order (MCO) on 18th March 2020, which essentially nationwide lockdown, with tight border control and closure of economic and government sectors. It was certainly a drastic move, but deemed necessary as COVID-19 cases were on the rise.

Despite the encouraging outcome seen after the implementation of the MCO, COVID-19 has caused significant disruptions and negative effects to the socioeconomic as well as mental health aspect. As the numbers of cases exponentially increased worldwide, there were growing concerns among public on fear of getting infected by COVID-19, as well as possibility of infecting their family members, especially the elderly and children (Holingue, Kalb, Riehm, Bennett, Kapteyn, Veldhuis, et al.; 2020) . With the closure of economic sectors, many businesses had to shut down, forcing many workers to be retrenched (Nicola, Alsafi, Sohrabi, Kerwan, Al-Jabir, Iosifidis, et al.; 2020; Blustein & Guarino; 2020). Schools and universities were forced to close, leaving students worrying about their future (Sahu, 2020; Lee, 2020). Apart from that, the daily routine of societies were no longer the same, having to adopt the new normal and observe social distancing (Shanahan, Steinhoff, Bechtiger, Murray, Nivette, Hepp, et al.; 2020; Fontanarosa, Bauchner; 2020).

These events have precipitated major psychological distress to the public. There has been growing evidences that suggested that mental health are significantly affected during the pandemic (Rajkumar; 2020; Yau, Ping, Shoesmith, James, Hadi, Lin; 2020; Ren, Huang, Pan, Huang, Wang, Ma; 2020; Shanmugam, Juhari, Nair, Chow, Ng; 2020). Anxiety, depression and stress were notably higher compared to previously, and it was anticipated that the prevalence of post-traumatic stress disorder (PTSD) will be increasing, similar to SARS epidemic in 2003 (Qiu, Shen, Zhao, Wang, Xie, Xu; 2020; Gardner & Moallef; 2015). In view of the increasing positive cases and deaths in Malaysia, public were fearful and extremely concerned about the situation and the possibility of extended lockdown. Therefore, this study aimed to identify the level of fear during COVID-19 among Malaysian adults, using the Fear of COVID-19 Scale (FCV-19S) instrument.

Materials and Method

Ethical approval was obtained from Universiti Malaysia Sabah (UMS) Medical Research Ethics Committee.

Sample and sampling

The target participants were the adult age 18 and above in Malaysia. As the current population of adult in Malaysia is around 22 million, thus based on Krejcie and Morgan formula (Krejcie & Morgan; 1970), the recommended number of sample size is around 384 participants. In this study, 840 respondents participated, exceeding the recommended number.

This study applied simple random sampling design as it has the least bias and offers the most generalizability (Uma & Bougie; 2013). This research adopted a survey approach using an online questionnaire. A questionnaire was prepared to gather demographic data and the study variable of the respondents during the COVID-19 pandemic using Microsoft Forms. The questionnaire was written in English language and distributed to all respondents via Whatsapp application. The data was collected between 29 April 2020 and 2 May 2020.

Fear of COVID-19 Scale (FCV-19S)

FCV-19S was developed to objectively assess fear of COVID-19 among individuals (Ahorsu, Lin, Imani, Saffari, Griffiths, Pakpour; 2020). It has seven items, scored on five-point Likert scale, ranging from 1 = strongly disagree, to 4 = strongly agree. The minimum score possible for each question is 1, and the maximum is 5. A total score is calculated by adding up each item score (ranging from 7 to 35). The higher the score, the greater the fear of COVID-19. This scale demonstrated robust psychometric properties, as evaluated by classical test theory and Rasch model analysis. It has Cronbach's alpha of .82 and good test-retest reliability (ICC = .72). The concurrently validity, ascertained with Persian version of Hospital Anxiety and Depression Scale (HADS) (Montazeri, Vahdaninia, Ebrahimi & Jarvandi; 2003) and Persian version of Perceived Vulnerability to Disease Scale (PVDS) (Ahmadzadeh, Ghamarani, Samadi, Shamsi, Azizollah; 2013: 43–51)., further confirmed that the FCV-19S as a valid tool to measure fear of COVID-19 (Ahorsu, Lin, Imani, Saffari, Griffiths, Pakpour; 2020). A Malay version of the scale was validated recently (Pang, Kamu, Hambali, Ho, Mohd, Mohamed, et al.; 2020), however for this study, as it was conducted prior to the publication of the validation, it still employed the English version.

Data Analysis

SPSS software was used for the analysis procedures. Descriptive statistics were computed in the form of numbers and percentages. Each item was calculated with its respective mean score and the average mean score for the responses. A t-test for two variables and analysis of variance (ANOVA) for three or more variables were used to identify the different of research variables based on demographic variables. Average mean score of the research variable was taken as a cut point in categorizing between low and high levels of FCV-19S. The scores that were less than or equal to the cut point (mean between 1 and 2.24) was

categorized into low fear group while scores that were above the average mean score (mean between 2.25 and 4) was categorized into high fear group. A binary logistic regression analysis was used to compare the defined low and high levels of fear with demographic variables, with a p-value less than 0.05 considered statistically significant.

Results

Analysis of Data

This study (Table 1) recorded 840 participants, with the majority being female participants (63.9%) while the other (36.1%) were male. Most respondents were young adults (70.7%) aged between 18 and 35 years-old and nearly one-third (29.3%) were aged between 36 and 56 years old. About two-thirds of the participants (68.2%) were single, 31.4% married, and 0.4% divorced. Similarly, about two-thirds (61.1%) of the respondents were undergraduate, 23.6% graduate, and 15.4% postgraduate. Most of the respondents (72.9%) stayed in urban areas while 27.1% stayed in rural areas.

Table 1: Distribution of respondents (N = 840)

Demography Variables	***N (%)***
Gender	
Male	303 (36.1)
Female	537 (63.9)
Age group	
18-35 years	594 (70.7)
36-56 years	246 (29.3)
Marital status	
Single	573 (68.2)
Married	264 (31.4)
Divorced	3 (0.4)
Education	
Undergraduate	513 (61.1)
Graduate	198 (23.6)
Postgraduate	129 (15.4)
Location	
Urban	612 (72.9)
Rural	228 (27.1)

Table 2 shows slightly more than half of the participants (53.2%) recorded high levels of fear as per the study definition, and the remaining (46.8%) at low fear level. Generally (Table III), the study population had a slightly high fear of

coronavirus 2019 as the FCV-19S score showed slightly high (2.24 ± 0.55).

Table 2: Status of fear (FCV-19S) based on demography variables

Variables	N (%)		p-value
	Low	High	
Gender			
Male	132 (15.7)	171 (20.4)	0.160
Female	261 (31.1)	276 (32.9)	
Age group			
18-35 years	312 (37.1)	282 (33.6)	0.000***
36-56 years	81 (9.6)	165 (19.6)	
Marital status			
Single	300 (35.7)	273 (32.5)	0.000***
Married	93 (11.1)	171 (20.4)	
Divorced	0 (0.0)	3 (0.4)	
Education			
Undergraduate	267 (31.8)	246 (293)	0.000***
Graduate	81 (9.6)	117 (13.9)	
Postgraduate	45 (5.4)	84 (10.0)	
Location			
Urban	309 (36.8)	303 (36.1)	0.000***
Rural	84 (10.0)	144 (17.1)	
Overall	393 (46.8)	447 (53.2)	-

*p < 0.05; **p < 0.01; ***p < 0.001, statistically significant

Table 3: Distribution of responses on FCV-19S items

		N (%)				
	FCV-19S	**Strongly disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Mean ±SD**
1	I am most afraid of corona virus-19	39 (4.6)	226 (26.9)	407 (48.5)	168 (20.0)	2.84 ± 0.79
2	It makes me uncomfortable to think about corona virus-19	54 (6.4)	315 (37.5)	390 (46.4)	81 (9.6)	2.59 ± 0.75
3	My hands become clammy when I think about corona virus-19	195 (23.2)	504 (60.0)	123 (14.6)	18 (2.1)	1.96 ± 0.68

4	I am afraid of losing my life because of corona virus-19	111 (13.2)	303 (36.1)	309 (36.8)	117 (13.9)	2.51 ± 0.89
5	When watching news and stories about corona virus-19 on social media, I become nervous or anxious	348 (41.4)	441 (52.5)	39 (4.6)	12 (1.4)	2.27 ± 0.77
6	I cannot sleep because I'm worrying about getting corona virus-19	348 (41.4)	441 (52.5)	39 (4.6)	12 (1.4)	1.66 ± 0.64
7	My heart races or palpitates when I think about getting corona virus-19	282 (33.6)	402 (47.9)	141 (16.8)	15 (1.8)	1.87 ± 0.74
	Overall Mean ± SD				2.24 ± 0.55	

Multivariate Analyses

A t-test was conducted for gender, age group, and location variables; whereas Analysis of variance (ANOVA) was performed to identify the difference of COVID-19 fear based on marital status and education variables (Table 4). Single marital status participants scored lower fear (2.17 ± 0.55) than a person who had already married (2.40 ± 0.52, $p < .001$), however, no significant difference between a married and divorced participant ($p > 0.05$); and single and divorced participant ($p > 0.05$). Our findings also show that postgraduate students reported higher fear (2.46 ± 0.57) as compared to undergraduate (2.18 ± 0.54, $p < 0.001$) and, graduates (2.28 ± 0.52, $p < 0.05$). However, the fear between graduate and undergraduate showed no different ($p > 0.05$). Other findings showed that male participants recorded greater FCV-19S (2.31 ± 0.59, $p < 0.05$), indicating greater fear. Younger adults (2.43 ± 0.57, $p < 0.001$) and people living in rural areas (2.36 ± 0.56) were recorded greater fear.

Table 4: Comparison of FCV-19S items based on demographics

Variables	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Overall
Gender								
Male	2.96 ± 0.75	2.62 ± 0.80	2.08 ± 0.77	2.53 ± 0.85	2.23 ± 0.78	1.77 ± 0.63	2.00 ± 0.75	2.31 ± 0.59
Female	2.77 ± 0.81	2.58 ± 0.72	1.88 ± 0.62	2.51 ± 0.91	2.30 ± 0.76	1.60 ± 0.63	1.81 ± 0.74	2.21 ± 0.52
p-value	0.001**	0.370	0.000***	0.798	0.216	0.000***	0.003**	0.010*
Age group								
18-35 years	2.71 ± 0.78	2.52 ± 0.75	1.84 ± 0.61	2.47 ± 0.90	2.23 ± 0.77	1.58 ± 060	1.80 ± 0.74	2.16 ± 0.52
36-56 years	3.16 ± 0.74	2.78 ± 0.72	2.23 ± 0.76	2.62 ± 0.87	2.37 ± 0.76	1.85 ± 0.67	2.02 ± 0.73	2.43 ± 0.57
p-value	0.000***	0.000***	0.000***	0.022*	0.021*	0.000***	0.000***	0.000***
Marital status								
Single	2.71 ± 0.79	2.50 ± 0.75	1.83 ± 0.63	2.49 ± 0.93	2.25 ± 0.78	1.59 ± 0.63	1.83 ± 0.77	2.17 ± 0.55
Married	3.13 ± 0.72	2.80 ± 0.71	2.23 ± 0.72	2.58 ± 0.81	2.33 ± 0.74	1.81 ± 0.62	2.00 ± 0.69	2.40 ± 0.52
Divorced	3.00 ± 0.00	3.00 ± 0.00	2.00 ± 0.00	2.00 ± 0.00	2.00 ± 0.00	2.00 ± 0.00	2.00 ± 0.00	2.29 ± 0.00
p-value	0.000***	0.000***	0.000***	0.228	0.286	0.000***	0.069	0.000***
Education								
Under-graduate	2.73 ± 0.77	2.52 ± 0.75	1.84 ± 0.65	2.54 ± 0.92	2.21 ± 0.77	1.58 ± 0.65	1.82 ± 0.76	2.18 ± 0.54
Graduate	2.97 ± 0.78	2.68 ± 0.72	2.08 ± 0.66	2.35 ± 0.79	2.29 ± 0.74	1.73 ± 0.54	1.88 ± 0.71	2.28 ± 0.52
Post graduate	3.07 ± 0.82	2.74 ± 0.75	2.26 ± 0.72	2.67 ± 0.89	2.51 ± 0.76	1.88 ± 0.66	2.05 ± 0.72	2.46 ± 0.57
p-value	0.000***	0.002**	0.000***	0.003**	0.000***	0.000***	0.008**	0.000***
Location								
Urban	2.82 ± 0.79	2.53 ± 0.76	1.91 ± 0.69	2.50 ± 0.89	2.23 ± 0.76	1.63 ± 0.64	1.79 ± 0.70	2.20 ± 0.54
Rural	2.89 ± 0.81	2.76 ± 0.71	2.08 ± 0.65	2.55 ± 0.88	2.40 ± 0.78	1.74 ± 0.62	2.08 ± 0.83	2.36 ± 0.56
p-value	0.340	0.000***	0.001**	0.444	0.005**	0.034*	0.000***	0.000***

*p < .05; **p < .01; ***p < .001, statistically significant

The relationship of fear with demographic variables were analysed using binary logistic regression (Table 5). Our findings indicated that people in their 36 to 56 age are more likely (2.25 times) to experience high fear than people who aged between 18 and 35 years-old. during the COVID-19 pandemic. Postgraduate students also reported more likely (2.02 times) to experience high fear than undergraduate students. Besides, people living in rural areas are 1.75 times more likely to experience high fear.

Table 5: Binary logistic regression analysis of fear based on demographic variables

Variables	**N (%)**	**High fear N (%)**	**OR**	**95% OR Lower**	***p*-value Upper**	
Gender						
Male	303 (36.1)	171 (20.4)	0.816	0.615	1.084	0.160
Female	537 (63.9)	276 (32.9)	Ref.			
Age group						
18-35 years	594 (70.7)	282 (33.6)	0.444	0.325	0.605	0.000***
36-56 years	246 (29.3)	165 (19.6)	Ref.			
Marital status						
Single	573 (68.2)	273 (32.5)	0.000	0.000	-	0.999
Married	264 (31.4)	171 (20.4)	0.000	0.000	-	0.999
Divorced	3 (0.4)	3 (0.4)	Ref.			
Education						
Undergraduate	513 (61.1)	246 (293)	0.494	0.330	0.737	0.001**
Graduate	198 (23.6)	117 (13.9)	0.774	0.489	1.225	0.247
Postgraduate	129 (15.4)	84 (10.0)	Ref.			
Location						
Urban	612 (72.9)	303 (36.1)	0.572	0.419	0.782	0.000***
Rural	228 (27.1)	144 (17.1)	Ref.			

*p < .05; **p < .01; ***p < .001, statistically significant

Discussion

Our findings suggest various salient points. Firstly, the majority of participants scored a high level of fear of Covid-19 based on the criteria specified. Secondly, middle-aged individuals, postgraduate students, and those living in rural areas are more likely to have higher fear of Covid-19. These findings were similar to the Chinese study, whereby older people reported poorer mental health (Qiu, Shen, Zhao, Wang, Xie & Xu; 2020). This may due to their cognitive difference, vulnerable to flooded information, hoax information, and unverified information (Nielsen, Fletcher, Newman, Brennen, Howard; 2020; Radwan, Radwan &

Radwan; 2020; Van den Broucke; 2020; Okan, Sørensen, Messer; 2020). Such cognitive difference could lead them to greater sense of fear and affect their mental health parallelly. Also, an interesting finding was where postgraduates had a greater sense of fear than younger undergraduates. In the period of great uncertainty, they might experience more fear, as they could be having more responsibility to bear in life, as compared to undergraduates (Rathakrishnan, Samsudin, Singh, Juliana; 2017; Ahmad, Rahim, Ud Din, Ahmed; 2020; Imran, Masood, Ayub, Gondal; 2020).

Additionally, people who are living in rural areas demonstrated greater fear, which is a worrying finding as there are poorer mental health services available compared to people who are living in the city to counteract this fear (Lyne, Roche, Kamali, Feeney; 2020). As the technologies and facilities in urban areas are more developed, people have better access to the latest information than rural areas, as well able to utilize telemedicine in times of restricted movement during lockdown (Rathakrishnan, Chan; 2013; Webster; 2020; Kannarkat, Smith, McLeod-Bryant; 2020). Unfortunately, people living in rural area did not have the same privilege as the urbans. Furthermore, apart from the connectivity and logistic limitation, rural population was also found to have significantly higher negative impact during the pandemic due to possible stigma and taboo regarding mental health issue (Druss; 2020; Ahamed, Hasan, Islam, Gali; 2020; Reyes-Foster, Duncan; 2020). Hence, mental health destigmatization and education to the aforementioned population is crucial; and shall be considered seriously in development of post COVID-19 strategies as this would aid vulnerable people back to their normal life functioning, for instance, social functioning and occupational functioning (Monteith, Holliday, Brown, Brenner, Mohatt; 2020; Rathakrishnan, Molugulu, Parasuraman, Narasappa; 2012).

In accordance with the new normal, innovative approach to deliver mental health service shall be adopted, with the idea of easing the access to the service and at the same, adopting safe standard operating procedure to limit the transmission of COVID-19. As mentioned previously, telehealth or telepsychiatry is certainly an interesting option and has been widely used in different countries, with encouraging responses were observed (Zhou, Snoswell, Harding, Bambling, Edirippulige, Bai X, et al.; 2020; Smith, Thomas, Snoswell, Haydon, Mehrotra, Clemensen, et al.; 2020; Corruble; 2020; Soron, Shariful Islam, Ahmed, Ahmed; 2020; Di Carlo, Sociali, Picutti, Pettorruso, Vellante, Verrastro, et al.; 2020). Moreover, the researchers suggest an open-access module of psychological first aid for the public so that they could not only self-help themselves but also help others in the time of need. An intervention called the Ultra Brief Psychological Interventions, which repackages complex psychological interventions into 10-15 minute bite-sized interventions that can be performed by a non-specialist operator, has been adapted and modified for fear related to Covid-19, and has been

successfully trialed both in healthcare workers on the Covid-19 frontline and also peer support workers on a telepsychology platform who are university students (Pang, Shoesmith, James, Nor Hadi, Eugene Boon, Loo; 2020; 27(2):51–6). Such interventions improve psychological mindedness which consequently can reduce the incidence of depressive symptoms (Pang, Masiran, Tan, Kassim; 2020).

As limitation of our findings, it still warrants further exploration, as the sample size can still be expanded by using larger sample groups across larger geographical areas. Also, due to the use of an Internet questionnaire due to the social distancing restrictions within the pandemic, there may be a recruitment bias due to the fact that only people with Internet access who are Internet literate will be able to answer this questionnaire. Moreover, during the time of the research, as there was still no Malay-version validated questionnaire available, it may not be able to be fully generalizable to the entire Malaysian population at large. Recall bias obviously is also present due to the limitations of online questionnaires. It is thus envisaged that this novel field of study requires more in-depth study longitudinally.

Conclusion

Older individuals and rural population are identified as a key target in this project, and there is a possibility in both groups that lower Information Technology literacy and consequently poorer access to updated healthcare information can create a vicious cycle of disinformation leading to further psychological disenfranchisement, leading to increasing fear. Hence, the findings of this study have crucial public health and policy making implications. With these findings, it is hoped to provide some resources for policy makers and mental health workers in Malaysia to act upon at-risk groups.

Conflict of Interest

All authors wish to declare that there is no conflict of interest. No funding was received for this study.

Ethics Approval and Consent to Participate

Ethical approval was obtained from both Universiti Malaysia Sabah (UMS) Medical Research Ethics Committee. All procedures were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all participants for being included in the study.

AUTHORS CONTRIBUTION

All authors contribute equally to data collection, data analysis, drafting the manuscript and gave final approval for the manuscript

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